Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Vear Month Day **Physician** MARY ELEANOR CULP FEBRUARY 17, 2009 8:02 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTER RIVER MANOR CHESTERTOWN KENT If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11/13/1914 Birthplace (State or Foreign Country) D A 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛛 F Months PA 94 Director 176-07-8000 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the five least trait in a found at 1 □Yes 2 □ No Directo MD KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 MORGNEC RD. APT. I-202 21620 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14 Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify: 3 Widowed 4 □ Divorced Year or Dates WHITE Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SCHOOL DISTRICT/ Elementary/Secondary (0-12) College (1-4or 5+) **12 EDUCATION** CAFETERIA MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ WILLIAM MARTIN SHEALER GRACE DILLMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any injury or other trau once. 8931 ORCHARD DR. CHESTERTOWN, MD 21620 JAMES H. CULP/SON 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 2/18/09 STEVENSVILLE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ng physician and as the burlal-tran Due to (or as a consequence of): P.O. Box 68760, pe Physician/Medical ed by the attending professional IF FEMALE: nse ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? res 2 No 1 ☐ Yes 2 ☐ No 1 Nes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) To the within 2 and manner stated. 29b. Signature and title of celtifier 29c. License number 29d. Date signed (Month, Day, Year)

5 5

State Registrar 31. Date filed (Month, Day,

FEB 1 8 2009

30 Name and address of person who completed case of death (Item 23a) (Type, Print)

SON MD 120 Speeck
32. Registrar's Signature

19 12 April

Bidg B Chestertown MD

			1- For Amend Items 7 & State of Maryland / Dep 1- Registrar 8 WCHD/SH 2/17/09 per FH Co	partment of Health and Me ertificate of Death		ene 009	06002
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
н	Physici		Stephane Anne Crotty Killgore Chilco	ote F	ebruary	11 2009	11:35PM
}	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
			1110 South Potomac St.	Hagerstown		Washingt	on
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birt	thplace (State or Foreign
	Director		038-32-6936 1 M 2 T 58 56 Yrs.		June 29,		Joseph, MO
	and w		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or in the country 10c. City, Town or in		June 29,	1950	10d. Inside City Limits
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	28e-i	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Co	
	with la or	ā	1110 South Potomac St.		109		ountry :
	leath	era		21740 3. Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	US 14. Race - Ame	arican Indian
36	72 hours after death with the Maryland naturel; or ttems 23a or 28e-f show dical Examinet must be multified at	by Funeral	Armed Forces? 1 ☐ Never Married 2 [X] Married 1 ☐ Yes 27☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puèrto R 1 ☐ Yes 🌠 No Specify:	Rican, etc.)	Black, Whit	
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212	d with	Completed		emaker		own hom	e
	e file al Hy rothe	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Sumame)	
<u>Ja</u>	uld b Ments arked	To	William F. Foley	Vera G.	Way		
Maryland	2 sho and I is me			iling Address (Street and Number or Rural			Zip Code)
	and sealth n 27		Raymond E. Chilcote 1110	South Potomac St.		town, MD	21740
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturel", or items 23a or 28e-f show any Injury or other treumatic event, It e Medical Examiner must be multiled at once.			position (<i>Name of</i> ematory or other place) Februan and Valley Crema.	-	c. Location - City or 009 aynesboro	
alti	mit. partm porte y Inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility G1			eral Home, I
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			23a. Part. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	respiratory arrest		Approximate Interval Between
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	/Medical		resulting in death) a	100 1100 10000	1		greats
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Вох	atter for u	clar	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of deli Month	Day Year
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S, D	requires that the een signed by th hould be detache	y PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds	w require been sig should b		Hone		1 Yes	2 □ No 3 □ Pr	obably 4 🗆 Unknown
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æ	0 5 0	Ho			autopsy performe 1 Yes 2	d? death?	completion of cause of
ta	ilcian: Th certificate ector, pag	Bec	25. Was case referred to medical	26. Place of Death (12 103	2010
<u></u>	Physician: r this certificant	To E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing Home	e 5 Residenc	e 6 Other (Spec	cify)
0 _	ding Ph h. After thi funeral		27. Manner of Death 1 ★Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury		d. Describe how	injury occurred	
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	ospitei hours a uneral D ly filled i						
	I 4 II 0	edlcal	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal call Examiner: On the basis of examination and/or in and manner stated.	ath occurred at the time, date and place, an investigation, in my opinion, death occurred	nd due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	n, Day, Year)
			MUL Stolms	D58810	te	bruary i	3,2009
t	15		30. Name and address of person who completed cause of death (Item 23a) (Type STEVEN BLASH, MD 324 E. Antictam S	/		-	<u> </u>
	Sta Registra	_	31. Date filed (Month, Day, Year) FEB 13 2009 32. Registrar's Signature	barles	,		
			Partie Pa	<u> </u>			

Division	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Medical Certificatio
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Physicia /Medic Examin	al	COLLEEN UNGEHEUER CAYTON 4a. Facility Name (If not institution, give street and number) 402 QUEENS COURT		4b. City, Town, or		of Death	Month FEBRUARY	7 8 4c. Co	Year 2009 Dunty of Death	9:00 AM
Funeral Director		5. Social Security Number 514-40-0380 G. Sex 1 □ M 2 ▼ F 67 Yrs Usual Residence of Decedent	s.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 1	B. Date of Birth (Month, Day,		9 Birtl	hplace (State or Foreign untry) NSAS
th the Marylan or 28a-f show	Director	10a. State 10b. County 10c. City, Town of MARYLAND QUEEN ANNE S 10e. Street and Number	or Loca	STEVEN 10f. Zip Code	SVIL	LE	10	g. Citizer	n of What Co	10d. Inside City Limits 1 ☐ Yes 2 ▼No untry?
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bur be	cal Examiner	23a. Par 1. Enter the disease, or complications that cursed the death. Do not shock, or heart failure. List only one cause on sch line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	:	the mode of dyir	ng, such as	s cardiac or	respiratory arres	st,		Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Ectopic pregnanc	у			230	d. Date of deli Month	very Day Year
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or Attending Physi after death. Director: After this of in by the funeral dire	Certification: To	Hospital: 1 Inpatient 2 ER/Outpate	ne of iry	28c. Injur Work M 1 🗆	4 ⊔ N	No	3d. Describe hov	v injury o	ccurred	ral Route Number,
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physiciar //Medica Examine

al or Attending Physician: The law requires that the death certificate be executed 's after death.

I Director: After this certificate has been signed by the attending physician and ed in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

To the Hosplt within 24 hour To the Funers completely fills
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ine	er	4a. Facility Name (If not institution, giv	e street and number;)		4b. City, Town,	or Location	n of Death			County of Deat		
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l r		5. Social Security Number 6. S 213-42-9372	Sex 7. Ag	ge (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		er 24 Hrs. 8 Min. 0	B. Date of Birtl (Month, Day 1/21/1	h <i>y, Year)</i> 940	Co	hplace (State untry) 'land	or Foreign
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1,	Be	17. Father's Name (First, Middle, Last,)				18. Mot	her's Name (First, Middle,	Maiden S	Surname)		
1	٥	Francis C. Carter					Mary	7 C. G1	reen				
		19a. Informant's Name/Relationship (Type. Print)		19b. Maili	ng Address (Stree	t and Nun	ber or Rural	Route Numbe	er, City or	Town, State, 2	Zip Code)	
		Charles Carter/So	n		38850	Tanji L	ane,	Clemer	nts, MI	20)624		
		20a. Method of Disposition		20b. P	lace of Dispo	osition (Name of matory or other pla	ice)	Dat	te	20c. Loc	cation - City or	Town, State	
		1 A Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				art Ceme	i	02/18/	/2009 E	Rucht	rood M	arvlan.	d
		21. Signature of Funeral Service Licer	1	-	2	2. Name and Addr	ess of Fac	ility	2007 I	T T	1 TT	ary rain	u
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	ij	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of In building, e	jury - At ho tc. <i>(Specif</i> j	ome, farm, sti y)	reet, factory, office		28	If. Location (S City or Tow	Street and vn. State)	d Number or Ru	ıral Route Nu	mber,
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	ž	29b. Signature and title of certifier		\		29c. Licen	se numbe	r	- 1	29d. Date	e signed (Mont	h, Day, Year)	
		1/0/	etty 17	1		DOC	54	263		01-	17-	1009	
		30. Name and address of person who	completed cause of	death (Item	1 23a) (Type,	Delan							·-
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 06005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 18,2009 ar February Steven Alan Cusic, Jr. 4:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mechanicsville 28002 Steeple Court St. Mary's 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 X M 2 □ F Days Hours Min. 213-59-0686 8 Director Maryland August 24, 2000 Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, from Medical Expenses must be redified at Director 1 □Yes 2K No St. Mary's Mechanicsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28002 Steeple Court 20659 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marîtal Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, Black, White, etc. and 2 should be filed within 72 hours after of tealth and Mental Hygiene. m 27 is marked other than "natural", or iter 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Steven Alan Cusic, Sr. Leslie Renee Morgan ည permit. Pages 1 and 2.
Department of Health an.
Important: If item 27 is m.
any injury or other. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie R. Morgan / Mother 28002 Steeple Court Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State February 21, 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens 2009 Leonardtown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 Kennetk 23a. Part 1. Enter the disease, or of mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): nding physician and use as the burlai-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery atter 3 Ectopic pregnancy cate has been signed by the atte page 2 should be detached for a Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given în Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐ Yes 2 KNo 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death,

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0055751 18 Jennifer Schmidt, D.O. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1/2 40900 Merchants Lane Ste. 205 Leonardtown, MD 20650 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Courtney

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 06007 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SOLENE 5:15 02 2009 06 DUNKLEY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** OWINGS Mills BALTIMORE 9826 Lyons Mill 9. Birthplace (State or Foreign Country)

TAMAICA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours 1 □ M 2 🕱 F 89 Yrs. NONE Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experiment but officed. 1 ☐ Yes 2 No Funeral Director BALTIMORE OWINGS MILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9826 MILL RD 21117 LYONS CANADA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 🗙 No Completed by Specify: BLACK 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th GRADE CLOTHING SEAMSTRESS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DUNKLEY CATHÉRINE ပ LINDSAY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IAN BLAIR-BROWN SON 9826 LYONS MILL RD OWINGS MILLS MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORÉ, MD PARK 02-15-2009 MEMORIAL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1713 COUNTRYWOOD 01441 MEBEAN SALSTON FIS LANDOVER MD 2078S 23a. Part 1. Enter the disease, or compile dions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** chrosse 00 /Medical Due to (or as a consequence of): Examiner CYA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). Hyperknemman

Due to (or as a consequence of): use as the burial-tran and attending physician IF FEMALE: NA 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by governszed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown umessire 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No ✓✓✓ 24a. Was an page 2 s autopsy performed certificate 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Physician: The law requires that the death certificate be executed P.O. Box 68760, of Vital Records, within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, l or Attending To the Hospital within 24 hours a To the Funeral C

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Registrar

(Check only

29b. Signature and title of certifier

m.D.

29c. License number

29d. Date signed (Month, Day, Year) 2-9-09

D 28530

21208 ann

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DINO PATEL OND WALKERAYE Smite: 202 19,

Durbin, Leoca

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, If a Medical Examinant to rutility at Once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1		Vas Decedent of H f Yes, specify Cuba I □ Yes 2 ∑ No	lispanic Origin? (S an, Mexican, Puerl Specify:	specify Yes or No o Rican, etc.)		nerican Indian, nite, etc.
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	To t Vith To t	Ž	29b. Signature and title of certifier	2	A	29c. Licens D359			29d. Date signed (Mo.	
	2		30. Name and address of person who con	mpleted cause of death (Item	23a) (Type 5				ebruary 6,	2003
			mina parteri,	M.D.		Wheato	niversity n, MD 209	902	#:4UU 	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-01473 State of Maryland / Department of Health and Mental Hygiene Robert E. Eckman Certificate of Death 1- For State Reg. No Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 19, 2009 1548 hrs Robert Emil Eckman Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Cecil Colora 159 Porters Bridge Road If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State of 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Pennsylvania Months Horirs Dec. 12, 1960 Director 218-70-4389 48 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 X No 28a-f show s 23a or 28a-f show enotified at once. Maryland Colora 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21917 USA 159 Porters Bridge Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status mnst be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 2 X No Yes White Yes. 2 X No specify: Specify: 3 XWidowed f Yes. Give Year Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 marked other than cevent, the Medical 21215-0036 Power Plant Supply/Parts 12 of Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther Fry Leo Allen Eckman, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) If item 27 is Baltimore, MD Leo Allen Eckman, Jr./Brother P.O. Box 52, Rising Sun, MD 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 02-23-2009 X Burial 2 Removal from State Cremation 3 West Nottingham Cemetery Colora, Maryland Donation 5 Other Specify 22. Name and Address of Facility
R.T. Foard Funeral Home,
111 S. Queen St., Rising gnature of Funeral Service Licensee. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21911 Approximate Interval Physician Between Onset and failure. List only one cause on each in Death Mudical Pneumonia Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit AMENDED 23a, PII, 27, perM, E g890 4/1/09 TT Physician/Medical fing physician ar X UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown has been signed by the att 2 should be detached for Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Р</u> Yes 2 No 3 Probably 4 V Unknown ģ Multiple sclerosis Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 2 Nο ✓ Yes 2 1 🗸 Yes page After this certificate 26.Place of Death (Check only one) Fo the Hospital or Attending Physician: 25. Was case referred to medical Other₄ examiner? Hospital: 1 DOA Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 Inpatient 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1 X Natural Yes 2 Pending 24 hours after death. Funeral Director: filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be 3 determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier February 20, 2009 O.C.M.E. OCME 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Month **Physician** 2009 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Days 1 XM 2 - F 59 07/16/1949 Director 255-80-7418 Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No notified 28a-f St. Mary's Maryland Lexington Park 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a c 21622 Forest Park Road 20653 Funeral United States death must items Was Decedent Ever in U.S. Armed Forces?
 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2X Married ō Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. à Specify. 3 Widowed 4 Divorced Year or Dates: White 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education the Medical (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene. 27 is marked other than 'r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Civil Servant U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Hugh Lee Edwards <u>Golda Marshalleen Harrisson</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 21622 Forest Park Road, Lexington Park, MD 20653 other t Djuna Bishop Edwards/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H
Important: If Ite
any Injury or ott 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 02/12/2009 Charlotte Hall, MD 22 Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hemorr **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) Box 68760, physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? Month detached for Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No Division of Vital Records, P.O. 9 Unknown 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 No 3 Probably page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Be 1 ☐ Yes 2 No Hospital: Other: $_{4} \square$ Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ 27. Manner of Death 28b. Time of 28c. Injury at Work? Date of Injury 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Pending investigation (Month, Day Year) Injury 1 🗌 Yes s after death. 2 🗌 No the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 🗌 Homicide To the Hospital 24 hours 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RESOOO MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 18 2009

32. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 02 2009 23:22p M Mary Frances 06 Freeman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)

DC 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Month Day Year, 3/19/18 Months Days Hours 1 □ M 2 🔀 F 90 117-28-6287 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County r than "natural", or Items 23a or 28a-f show the Madical Exemple: must be notified at 1X Yes 2 □ No MD Silver Spring Director Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 United States 11629 New Hampshire Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify. Specify: ð Black 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) Government Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Is marked of Jesse Janifer Robert Jones 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau Veronica F. Coleman-Davis P.O. Box 1213, Memphis, TN 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/10/2009 Beltsville, MD Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. noto) hon 7400 Georgia Avenue, NW Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transi Failure to Thrive resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 🖾 No ed by the 9 Unknown 9 Unknown signed l 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perform certificate 1 □ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1₺ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Box 68760 Ö ۵. Division of Vital Records, al or Attending P s after death. Il Director: After i fo the Hospital vithin 24 hours a b the Funeral D Hospital

pe

r death v

hours after

72

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State Registrar

(Check only one)

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

2/7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Nooshin Farr, 1500 Forest Glen Road, Silver Spring, MD

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Registrative No. 19toper FH, 2/17/09, BM, McGertificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day}, 2009 February **Physician** P M Helen Margaret Finch 2:27 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Spring House at Westwood Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth7-11-1923 9. Birthplace (State or Foreign (Month, Day, Year) 5 78-44-0782 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖺 F Months Days Hours Min. 85 Australia **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedical Evanchian must be notified at once. MD Bethesda 1 ☐ Yes 2 No Montgomery Director 10f. Zip Code **208**17 10g. Citizen of What Country? 10e. Street and Number United States 8301 Carderock Drive Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married ☐Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No White Specify: þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Gillies Thomas McIntyre ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Toyng Caty, Zip Code)
8301 Carderock Dr. Bethesda, MD 20016 19a. Informant's Name/Relationship (Type. Print) 8301 Carderock Dr. Bethesda, MD John Finch/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/09/2009 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or compilifations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final years **Physician** Inanition disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner years Dementia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burlal-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? 1 □ Yes 2 🗓 No 3 Ectopic pregnancy Month Day 4 Pregnant at time of death signed by the a 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown s peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 🔼 No this certificate 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 \ Residence 6 Other (Specify) 1∐ Yes 2∭ No 2 ER/Outpatient 3 DOA ဥ 1 Inpatient After the 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide

Box 68760. o σ. of Vital Records, Division

neral Director: y filled in by the To the Hospital within 24 hours a To the Funeral Completely filled

> State Registrar

Medical

DHMH 17 Rev 1/2001

Lila McConnell MD

29b. Signature and title of certifier

29a. Certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the date and place and place and place, and due to the cause(s) and manner as stated.

D39456

5530 Wisconsin Ave., Suite 1400 Chevy Chase, MD

29c. License number

29d. Date signed (Month, Day, Year)

02/09/2009

State Registrar 31. Date filed (Month, Day, Year)

FEB 2 4 2009

Ling Li, MD

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

February 19, 2009

amended item #1/wchd/2-20-09/map Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /		irtment of H		lental Hygi	ene g. No 200	9 06015
			Registrar 1. Decedent's Name (First, Middle, Last) Nancy Ellen			Jean	2. Date of Death		3. Time of Death
	Physicia		Nancy Ella Foreman		eman		Februser	5 20	ear
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	Lymny	4c. County of I	Death
A.			PENISSULA REGIONAL MEDICAL CENTE		ک_	AUSBURY		HI	DOM ICO
н	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		213-14-7527 13 13 14 15 15 15 15 15 15 15	113.			June 25,	1921 N	Maryland
yland	MOI THE		10a. State 10b. County 10c. City, Tow	n or Lo	cation				10d. Inside City Limits
Mar	a-f si	ctor	MD Worcester Snow	Hi11					1 □Yes 24□No
E E	or 28	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wha	t Country?
death with the Maryland	ntal Hygiene. Ind other than "natural", or items 23a or 28a-f show event, the Madical Examinat must be notified at		5213 Double Bridge Road	1	21863			USA	
er de	items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	13. V	Vas Decedent of Hi fYes, specify Cuba	ispanic Origin? (Spo n, Mexican, Puerto	ecity Yes or No- Rican, etc.)		American Indian, Vhite, etc.
OU36 hours after	al', or	by	3 🛣 Widowed 4 Divorced Year or Dates:	1	□Yes 2KINo	Specify:		Specify:	Black
5-0036 72 hours af	ical E	Completed	15. Decedent's Education (Specify only highest grade completed)	. Deced	lent's Usual Occupa	ation	10	6b. Kind of Busin	ess/Industry
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yland uld be file	ntal F ed otl	a	17. Father's Name (First, Middle, Last)			18. Mother's Name			
	f Health and Menta Item 27 is marked other traumatic ev	၉	Elijah Ayres 19a. Informant's Name/Relationship (Type. Print) 19	n Mailin	g Address (Street a	Effie Vi and Number or Rura			te Zin Code)
۾ ج			1		•	cle - New		•	
s ar	of Health item 27 i other tra		20a. Method of Disposition 20b. Place of compete	of Dispos	sition (Name of natory or other place	; [Oc. Location - City	
aitimore, mit. Pages 1 ar	int: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	r/Mt	Wesley UM	Feb.	14. 2009	Snow Hi	11, Maryland
E	Department of H Important: If ite any Injury or ot once.		21) Sign ture of Funeral Service Licensee		. Name and Addres			y, Maryla	
n e			Harrial Jalley	Jo	11ey Memor:	ial Chapel	- 1213 Jers	sey Road 2	1801
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente	er the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
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	Medical kaminer		resulting in death) Due to (or as a consequence	of):				- /	
		ē	Sequentially list conditions, b. Due to (or as a consequence	of):					
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6U, be executed	an an rial-tra	Exa	resulting in death) Last	of):					
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	ing pl	Med	IF FEMALE:						
death certifi	certificate has been signed by the attending rector, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat		Ectopic pregnancy	/		23d. Date of Month	f delivery Day Year
ક	the s	ysic	1 Yes 2 No 4 Pregnant at time of death	5∟	Other (specify)				·
ords, P.O	ed by detac		Part II. Other significant conditions contributing to death but not resulting	in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribu	te to the cause of death?
Kecords, he law requires t	n sign Ild be	d by					1 ☐ Yes	2 □ No 3 □	Probably 4 🔲 Unknown
ecol	s bee	Completed					24a. Was an	2,4b. Wer	e autopsy findings available
	age 2	mo					autopsy performe	ed? dea	r to completion of cause of th? Yes 2 DNo
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of Vita Physician:	his ce I direc		examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	utpatier	t 3 DOA Othe	er: 4 🗆 Nursing Ho	me 5 🗌 Residen	ice 6 □Other (Specify)
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SIO	tor: / the fi	cati	2 Accident investigation			Yes 2 ☐ No	004 Lanation (0)		Owel Contact to
DIVISION Il or Attending	after of Direction by	Certification: To	4 Homicide	arm, stre	еет, тастогу, опісе		City or Town,	eet and Number of State)	or Rural Route Number,
s spital	neral rilled		29a. Certifier 1 Certifying Physician: To the best of my knowledge	je, deatl	occurred at the tir	ne, date and place,	and due to the car	use(s) and mann	er as stated.
e Ho	within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.						
To t	withi To th comp	Me	29b. Signature and title of certifier		29c, License	e number	29	d. Date signed (A	Month, Day, Year)
			* Winherlin VI	10	DO	50515		2/6/00	}
6	nof		30. Name and address of person who completed cause of death (Item 23a)	(Type,	Print)	- 1/		1	1 1 1 2 1 2
(P)			31. Date filed (Month, Day, Year) 32. Negistrar's Signature	Ex	STICKIN S	HOIZE DI	2 5/10	-15KUK	1 NID 21804
	Sta Registr		FEB 1 2 2009 Lanua B.	1	wed				

1 - State Registrar

1, Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Reg. No. 2009

2. Date of Death

State of Maryland, Department of Health and Mental Hygiene
Amend Item 8 per fh, g898, 12/22/09dhb
Certificate of Death
Reg. No.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State	of Mary		artment of r <i>tificate of</i>	Health and I Death		giene Reg. No2 () (09 06017
	Physici	an	1. Decedent's Name (First, Middle,	Last)					2. Date of Dea Month	Day	3. Time of Death
	/Medic		Marvin Eugene l							10/2009	3:00 p ^M
	Examin	er	4a. Facility Name (If not institution, 415 Dogwood Dri	-	umber)		Lusby	or Location of Death		4c. County of	
	Funeral	-		6. Sex	7. Age (i	In yrs. last birthday)	If Under 1 Year		8. Date of Birt	{	9. Birthplace (State or Foreign
	Director		224-24-1527	1 🖾 M 2 🗆 F	84	Yrs.	Months Days	Hours Min.	11/13	/1924	Radford, VA
	pui 🛊		Usual Residence of Decedent 10a. State 10b. County		10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	/aryla	ō	MD Calver	. 4-		-	04.1011				1 ∐Yes 2 XNo
	r 28a-	irect	10e. Street and Number	<u></u>		Lusby	10f. Zip Code			10g. Citizen of W	/hat Country?
	h with	a D	415 Dogwood Dri	ive				20657		U	.S.A.
	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or Items 23a or 28a-f show ent, I'm Medical Evin in court is northing	Funeral Director	11. Marital Status	12. Was Dec Armed F	orces?	er in U.S. 13.	Was Decedent of	Hispanic Origin? (Sp ban, Mexican, Puert	pecify Yes or No- Rican, etc.)	- 14. Race Black	e - American Indian, c, White, etc.
20	s afte	by F	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ⊠Yes If Yes, G Year or I	iive	7/1943 - 1/1944	1∐Yes 2∏xNo	Specify:		Specify:	White
3-003p	2 hour	ted	15. Decedent	s Education		16a. Dece	dent's Usual Occ	upation	- 1	16b. Kind of Bus	
2	hin 72 e. an "na Medi	Completed	(Specify only highes: Elementary/Secondary (0-12)	-) (1-4or 5+)	(Give	kind of work done DO NOT use retir	e during most of worl red)	king		
7	ed wil	Col	7			Truc	k Driver		(F) 18 - 1-10 -	Transpor	
yland	be fill ntal H ed oth	Be	17. Father's Name (First, Middle, L	.ast)					. Updike	Maiden Surname	9)
Š	hould id Mei mark matic	은	Terry Gordon 19a. Informant's Name/Relationsh	in (Type Print)		19b Mailir	na Address (Stree	et and Number or Ru			State Zin Code)
<u>8</u>	nd 2 s alth ar 27 is rtrau		Delores Farmer								1boro, MD 20772
ē,	is 1 ar	l i	20a. Method of Disposition			20b. Place of Dispo cemetery, crer			Date	<u> </u>	City or Town, State
Ē	Page nent c ant: If ury or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		n State	Washington		i	6/2009	Suitland	d, Maryland
Daltimo	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Event fine 1 and 15 m. Item 4 once.		21. Signature of Fundal Service I	icensee	n rel	\sim	2. Name and Add		ne. P.A.	4739 Ba	altimore Avenue ville, MD 20781
			23a. Part1. Enter the disease, or	complications that	caused the						Approximate Interval Between
4	Physician	¢ή	shock, or heart failure. List of Immediate Cause (Final disease or condition			TAC	ARRH	HMI	Ä		Onset and Death
	/Medical		resulting in death)	-		onsequence of):	Will the Williams Co.	NO.			
	Examiner	_	Sequentially list conditions,	D	-		ARTER	A DIO	EASE		
7	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are ultimated to the conditions of the condi	Due to	or as a c	onsequence of):					
_	execu n and al-trar	Exar	that initiated events resulting in death) Last	c Due to	(or as a c	onsequence of):					
Ø/00,	ficate be executed physician and s the burial-transit	dical		d							
	ertifica ing ph e as th	Medi	IF FEMALE:	_							
Š	ding Physician: The law requires that the death certifi. h. After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		birth 2	Fetal death 3	Ectopic pregna			23d. Date Mor	e of delivery oth Day Year
- -	he de / the a	ysic	1 □Yes 2 □No 9 □ Unknown	4 □ Pre		ne of death 5	Other (specify)				
Γ.	that the post of t		Part II. Other significant conditio	ns contributing to	death but r	not resulting in the u	nderlying cause g	given in Part I.	23e. Did to	obacco use contri	ibute to the cause of death?
cords	quires in sign	d by							1 🗆 1	res 2□No	3 Probably 4 Unknown
20	aw re	plete							24a. Was	an 24b. W	Vere autopsy findings available
Ĕ	The I	Completed								rmed? 🔔 d	rior to completion of cause of eath? □Yes 2 □No
V I Ca	cian; ertific ector,	Be (25. Was case referred to medical examiner?	11	-			26. Place of Dea	th (Check only o	ne)	
5	Physi this c	1.	1 Yes 2 ₩10		Inpatient of Injury	2 ER/Outpatier	11 3 L DOA			dence 6 Othe	
	ding h. After funer	tion	1 ☐ Natural 5 ☐ Pending	(Mo	nth, Day, Y		W	ork? □Yes 2□No	200. Describe r	low injury occurre	eu
DIVISION	Attending r death. ector: After by the funer	ifica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Plac	e of Injury	- At home, farm, str			28f. Location (S	Street and Numbe	er or Rural Route Number,
5	tal or s afte al Dir	Certification:	4 ☐ Homicide determi	bulk	ding, etc. (<i>Зресну)</i>			City or Tou	vn, State)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Medical		xaminer: On the		kamination and/or in		time, date and place y opinion, death occu			nner as stated. and due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of dertifier					nse number			(Month, Day, Year)
	_		Attenta	Λ , M	D		D6	7788		2	11.2009
e	5		30. Name and address of person					0 > () = (0.30	6	
	- 0		LEENA KAOK(31. Date filed (Month, Day, Year)	22	Dogiotror's	Cianaturo	RUEMAN	KD, SUTT	E 2300	, DOLOM	IONS, MD-20688
	Sta Registr		4 4 4444	knewa	1. 14	race					

		Pleas								I Copies A		egible.		
		For State	State o	of Marylan	-	artmen <i>rtificat</i>			and M	fental Hygid	ene g. No. 🤈	000	000	2 1 0
		Registrar 1. Decedent's Name (First, Middle,								2. Date of Death		. U U 3	3. Time of	Death
Physicia /Medica			5 ECR 66		SME		_			February			5:02A	M
Examine	r	4a. Facility Name (If not institution, St. Mary s Hosp 5. Social Security Number	-	7. Age (In yrs.	last hirthday)		nard	Location of Lown		8. Date of Birth		unty of Death Mary		Foreign
Funeral Director		217-26-0821	X M 2□ F	79	Yrs.	Months	Days	Hours	Min.	August 2	,19	29 M	iryland	
death with the Maryland ims 23a or 28a-f show fritted at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Charle	s		ty, Town or Lo		Code			140	Citizon	of What Co	10d. Inside City	
3a or		10e. Street and Number 14225 Meadow Cr	eek Lane			10f. Zip	0601			10	USA		and y :	
after or ite	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 X Divorced	12. Was Dec Armed Fo	edent Ever in U orces? 2 No ive		Was Deced f Yes, spec	cify Cubar	spanic Ori n, Mexican Specify:	, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White pecify:		
2 should be filed within 72 hours and Mental Hygiene. is marked other than "natural", aumatic event, I've Medical Exa	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	life. L	dent's Usua kind of wo DO NOT us urity	rk done d se retired)	uring mosi	t of work	ing		of Business/I		
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, Ite Medionce.	To Be Co	17. Father's Name (First, Middle, La George F. Fish	,					18. Mothe		e (First, Middle, Ma Snyder	aiden Sur	rname)		
2 shouland Nishmal		19a. Informant's Name/Relationshi	p (Type. Print)		19b. Mailir	g Address	(Street a	ind Numbe	er or Run	al Route Number,	City or To	wn, State, Z	ip Code)	
1 and Health em 27 ther tr		Diane Vest/Daugh	ter	20h s						e, Waldor		D 206		
Pages ent of nt: If its y or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	Place of Dispo cemetery, cren insfiel			1		uary			Hall, M	D
permit. F Departm Importar any Injus		21. Signature of Funeral Service Li		DI	22	. Name ar	d Addres	s of Facilit	y Br i	insfield-				
80 E # 9		23a. Part 1. Enter the disease, or c	wit	MO0817						Rd., Char		е нат.	Approximate	JOZZ
Physician /Medical		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a.	each line. ANA (or as a conseq	uence of):	ysar	THE	M14	5				Interval Betw Onset and D	
Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	(or as a conseq	uence of):	yo CA	NOT	AL in	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	TARC 11	ON		VENO	,
0 ⊂ 0	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to	(or as a conseq						1SEASE	•		YEAR	<u> </u>
eath certifice attending ph for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnation] Ectopic p	regnancy	,			23d	. Date of deli		
the dea y the att	ysici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nant at time of		Other (sp						Month	Day Ye	ear
e law requires that the de has been signed by the e 2 should be detached	ੋ≲	Part II. Other significant condition	s contributing to c	leath but not res	ulting in the ur	nderlying c	ause give	n in Part I.			cco use		the cause of de	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the bur	Completed									24a. Was an autopsy performe	1	prior to o death?	topsy findings a ompletion of ca	vailable use of
sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:				Othe			h (Check only one)				
g Physer this eral dil	2	1 Yes 2 1 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time of		8c. Injury	at at		me 5 Residen			eify)	
ending sath. or: Aftu he fun	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	nth, Day, Year)	Injury	М	Work 1 □ Y	? ′es 2 🗆	No					
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place build	e of Injury - At hi ling, etc. <i>(Speci</i>	fy)					28f. Location (Stre City or Town,	State)			er,
e Hosp e Fune	Medical	29a. Certifier (Check only one) 1 □ Certifying 2 □ Medical E	xaminer: On the	e best of my kno casis of examina nner stated.	owledge, deatl ation and/or in	n occurred vestigation	at the tim , in my op	ne, date ar pinion, dea	nd place, ath occur	and due to the car red at the time, dat	use(s) an te and pla	nd manner as ace, and due	stated. to the cause(s)	
To th withir To th comp	Me	29b. Signature and title of certifier	*	4	^	290	License				1	igned (Month	-	
		1/00	~		11)			160	76		21	13/0	9	
		3/11	ZR S.	se of death (Iter	STMI		M	08pr	Tor	LÉTNA	ND.	Town	MD 26	Z30.
Stat Registra		31. Date filed (Month, Day, Year)	2009 2	sund	1. be	de								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Marianne Grevers Fernandez **February** 17, 2009 7:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 30110 Broken Arrow Lane Mechanicsville St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** December 24, 1941 Netherlands 67 Months Days Hours Min. Director 073-34-0835 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Oppartment of Health and Mental Hygiene. Important: If the 23 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modical Exprise must be notified at Maryland ST. Mary's Director Mechanics ville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30110 Broken Arrow Lane 20659 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 □Yes 2 No Specify: WHITE If Yes, Give Year or Dates: Specify 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Financial Analyst L3-Titan Group d 2 should be filed w. th and Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gerrit Jan Grevers Antje Van Egmond ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a Robert V. Fernandez/Husband 30110 Broken Arrow Lane, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Feb 2732009 1 Burial 2 Cremation 3 Removal from State Arlington Natl. Cemetery Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service Licensee M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Du no (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated acress) Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 Other (specify) the 9 Unknown Ś signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 100 24a. Was an cate has I page 2 s autopsy performed certificate 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ိ 27. Mann u of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

State Registrar David Federle, Hollywood, MD 20636

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

31. Date filed (Month, Day,

FEB 20

29b. Signature and title of certifier

egistrar's Signatu

D34198

29d. Date signed (Month, Day, Year)

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2009 Fo1k /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death () 4c. County of Death Examiner Washington County Hospital Hagerstown
If Under 1 Year If Under 24 Hrs. Washington 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 1946 West Virginia 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 1 F Months Days Hours Director 236-74-0144 62 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show th and Mental Hyglene.
7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Exp. its must be notified at Director 1 ☐ Yes 2 ☑ No Berkeley Falling Waters 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 807 Grade Road 25419 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook School System permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event sonce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles A. Knadler Evelyn M. Custer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel W. Folk/Husband 807 Grade Road, Falling Waters, WV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Resthaven Crematory 12/24/2009 Frederick, MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit montry nrome Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached for 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should Mellitus 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HOD61117 E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) $\rightarrow 57$ anie(s trancisco 4098573un 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 26 Registrar

		-	For State Registrar	State of Ma	ii yiatiu /		tificate of L	Death		Reg. No.	009	06021
	Physicis		1. Decedent's Name (First, Middle, Las	•	GREEN	<u>. </u>			2. Date of De Month	Day		3. Time of Death
	Physicia /Medic	al .	JESSE CLA 4a. Facility Name (If not institution, give	XTON	GREEN.		4b City Town or	Location of Death	Feb.		2009 County of Deatl	9:24A
	Examin	er	Shady Grove Ad	ventist	Hospi	tal	Rock	ville			Montgo	omery
	Funeral Director		233 30 0030	7. Age	82	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 1	ıy, Year)	Co	hplace (State or Foreign untry) eorgia
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Loc	cation					10d. Inside City Limits
	a-f she	ctor	MD Prince	Georges		Cap	itol He	ights				1XTYes 2 ☐ No
	or 28	Funeral Director	10e. Street and Number				10f. Zip Code				zen of What Co	untry?
	ns 23a	era	1523 Pacific 11. Marital Status	12. Was Decedent E	Ever in U.S.	13. V		743 lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		S.A. 14. Race - Ame	
020	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, I'm Modorl Evantine must be notitinal at		1 ☐ Never Married 2 【★Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:	10		fYes, specify Cuba I∐Yes 2√∑No	Specify:	Hican, etc.)		Specify: B	
1215-0036	72 ho 'natur	Completed by	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work	ing	16b. Kii	nd of Business/	Industry
7	within iene. than	omp	Elementary/Secondary (0-12) 9th	College (1-4or 5	+)	Coo	_			Res	staura	nt
yiand		To Be C	17. Father's Name (First, Middle, Last) J.B. Greene					18. Mother's Name	e (First, Middle ie War		Surname)	
Mary			19a. Informant's Name/Relationship (and Number or Rui				
	1 and 2 Health tem 27 other tr		Alethea Greene	e-Daughte					apitol Date		ecation - City or	MD20743 Town, State
E O	Pages nent of hant: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				sition (Name of natory or other place Mem Gar	dens2/1	4/09	Pl	ymouth	, Township
Baitimore,	permit. Pages Department of Important: If it any injury or once.		21. Signatu of Funeral Service lice	Suo	uch	22	2. Name and Addre	ss of Facility S:	nowden			Home, PA , MD20850
			23a. Part 1. Enter the dis + se, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death.							Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. PNE	UMONIA							
	/Medical Examiner			Due to (or as	a consequence	e of):						
	D .±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events are utilized in death).	Due to (or as	a consequence	e of):						
5	tificate be executed ig physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequenc	e of):						
68760,	te be e ysician e buris	edical E		d								
_	ing phy		IF FEMALE:						-			
P.O. Box	the Hospital or Attending Physician: The law requires that the death certifich hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending p the Funeral Director, after this certificate has been signed by the attending p appletely filled in by the funeral director, page 2 should be detached for use as	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal dea		☐ Ectopic pregnand ☐ Other (specify) _	су			23d. Date of de Month	livery Day Year
	w requires that the d been signed by the should be detached		Part II. Other significant conditions			j in the u	nderlying cause giv	ven in Part I.				o the cause of death?
ords	equire sen sig ould b	ted b	End Stage Re						-			robably 4 Unknown
Vital Records,	The law rate has by page 2 sh	Completed by	Congestive H	eart Fal	lure				perl	s an opsy ormed? 2 XNo	prior to death?	utopsy findings available completion of cause of s
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Ott	26. Place of Dea			0	7.1
0	ding Physician: The h. h. After this certificate h. funeral director, page	5.	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	ent 2 ER/	o. Time o	nt 3 🗆 DOA	4 LI Nursing H	ome 5 ☐ Res 28d. Describe		6 ☐ Other (Sperry occurred	эспу)
ion	ending sath. or: Afte he fun	atio	Natural 5 Pending 2 Accident inveŝtigatio			Injury	M 1 🗆	Yes 2 □No				
Division of	pital or Attencours after deathers after deatheral Director: filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	20e. Place of In	jury - At home, tc. <i>(Specify)</i>	farm, st	reet, factory, office			(Street ar wn, State		lura I Route Number,
	the Hospita hin 24 hours the Funeral mpletely filled	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis and manner st	of examination	dge, dea and/or i	th occurred at the t nvestigation, in my	time, date and place opinion, death occu	e, and due to th	e cause(s e, date an	s) and manner a d place, and du	as stated. e to the cause(s)
	within 2	Me	29b. Signature and title of certifier	(1)	vi	NE	7	se number 2435			te signed (<i>Mon</i>	
			30. Name and address of person who Sayed Eisayyed	completed cause of	death (Item 23	a) (Type	Drint)		Lle ,M			
	St	ate	31. Date filed (Month, Day, Year)									
	Regist		FEB 11 20	U9 Centus	trar's Signature	100	New York	·				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend #26 per phys, DOR, Registrar 2/12/09, LDB Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, Physician Gearhea /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner 1A1but Under 24 Hrs. Luter Talbot Hospice House Birthplace (State or Foreign Country) If Under 1 Year_ 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 ☑ M 2 □ F Yrs. 273.03.043 104 Texas **Director** Usual Residence of Deceden 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 1 XYes 2 □ No Funeral Director Royal Oaks Maryland Talbot 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21662 USA 6591 Cedar Cove Rd 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. δ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) President / CEO Electronics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Naomi Wilson Arthur Gearheart ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 328, Royal Oaks, MD 21662 Eleanor M. Gearheart / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 2/10/2009 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Mid Shore Cremation Center 21. Signature of Funeral Service License 22. Name and Address of Facility Mid Shore Cremation Center, 2272 Hudson Rd., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Jeumani A /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed HYPER &USDA and burlal-trai attending physiclan for use as the burla Division of Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No his certificate has been signed by the director, page 2 should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Pother (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 522

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06023 Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Isemore Greene erome February 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Easton Easton Talbo If Under 1 Year | If Under 24 Hrs. . Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number Days Hours Months 1 1 M 2 □ F 963 215-88-9982 Maryland Feb. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 □ No Talbot XFord 10g. Citizen of What Country? 10e. Street and Number 21654 6330 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bike Repairman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vertina Greene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vertina Oxford, Maryland 21654

20c. Location - City or Town, State 26330 Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Trappe, Maryland 22. Name and Address of Facility Henry Funeral Home, P.A. 510 Washington St. Cambridge, MD: 21613 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final wowic disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 TVes 2 TNo

death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician

Examiner

Funeral

Director

12 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Morfield Expansion must be notified as

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be 1 nent of Health and Mental

Department of Health Important; If Item 27 any Injury or other tronce.

Physician

/Medical

Examiner

green, Jerom

/Medical

Director

Funeral

Completed by

Be

၉

Examiner

ician/Medical

e attending physician and d for use as the burial-tran

che t	Phys	9 Unknown	9 🗀 Unknown			
been signed by the should be detache	Ď	Part II. Other significant conditions of	contributing to death but not resulting in the underly	ving cause given in Part I.		use contribute to the cause of death?
ate has page 2	Completed	Per phe	ral Vascular	disease	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ertific ctor,	Be	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	
nysic lis ce direc	10 1	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing H	ome 5 Residence	6 ☐Other (Specify)
ath. or: After the	ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inju	ury occurred
s after de	Certifica	3 Suicide 6 Could not b 4 Homicide determined		actory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
n 24 hour n 24 hour ne Funera	dical		nysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investig and manner stated.			
withii To the	Me	29b. Signature and title of certifier	2	29c. License number	29d. D	ate signed (Month, Day, Year)

State

Washington Street, Easton, MD 21601

D0053110

February 9 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 219 S. Dennis M. DeShields, 31. Date filed (Month, Day, Year)

FEB 11 2009

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#10eperFH2/11/09, BMW, MoCo Reg. No. 2. Date of Death Physician 2009 q00;01 06 02 Mildred E. Harris /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Prince George Fort 6801 Bock Road #207 9. Birthplace (State or Foreign Country)
S.C. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days | Hours | Min. | 1 2 / 5 / 25 7. Age (In vrs. last birthday Social Security Number **Funeral** 1 ☐ M 2√2 F 83 578-42-5859 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Everning must must be notified at agnee. 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State 1 X Yes 2 No Fort Washington Prince George Md Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20744 6801 Bock Road Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Š 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Teacher 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella E. Walker Leroy H. Ellis မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2740 Lorring Dr#203 Forestville,Md 20747 Daughter Marita Tyler 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02/14/09 Washington, DC Glenwood 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snead Mortuary Service, P.A. 21. Signature of Funeral Service Licenses 1409 Fairlakes Pl Ste B mitchelville, Md Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cardiac Arrest /Medical Due to (or as a consequence of) Examiner Ischemic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Diabetes Mellitus signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical Hypertension IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 1 Yes 2X No 9 III Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Cerebrovascular Disease 24b. Were autopsy findings available prior to completion of cause of death? Severe Degenerative Arthritis autopsy performed 2 🗆 No 1 □Yes 1 ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

completely filled in by the funeral

State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Obiora Ogbuawa, M.D.

FEB 11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11701

Livingston RD

D0024523

29d. Date signed (Month, Day, Year)

02/09/2009

Fort Washington, Md 20744

State of Maryland / Department of Health and Mental Hygiene, 06025 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 **Physician JAMES** W. HAWKINS 5,_ FEB. 0450 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville MONTGOMERY Shady Grove Adventist Hospital 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Social Security Number 6. Sex **Funeral** Months 1 → M 2 □ F Maryland 214-18-8512 88 Director Usual Residence of Decedent mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Ex miner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 ☑ No Gaithersburg Montgomery MD Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20882 U.S.A. 9350 Brink Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 ☐ No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. Baltimore, Maryland 21215-0036 Specify: Black þ Year or Dates: 3 □ Widowed 4 □ Divorced 42 - 45Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State Highway Elementary/Secondary (0-12) 7th College (1-4or 5+) Commission Sign Maintanence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maude Hawkins Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 335 Lincoln Ave, Rockville, MD 20850 Melvin O. Hawkins (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Buria 2 ☐ Cremation 3 ☐Removal from State permit. Page Department of Important: If any Injury or once. Parklawn Mem Park 2/13/09 Rockville, MD 4 Doyation 5 Dother (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Sign dur of Funeral Service L 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failyire. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Anonic Encephalopathy disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Hypothermia
Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hypotension Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical End Stage Renal Disease IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed? 2 No 1∐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Xnpatient 2 □ ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 XcertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number tixe of certifie 29b. Signature ar FEBRUARY 05,2009 13 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) Sujatha Ramaseshan, M.D. 9901 Medical Center Dr, Rockville, MD 20850 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Day 7, 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Stephen Harhai, Sr. 7:20 p M February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sharon Nursing Home Sandy Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, May 21, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1**™** M 2□ F Days Hours Min. 578-03-6870 95 1913 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-4 shown any Injury or other traumants and items. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3536 Fiske Terrace 20906 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 In No Specify: White ₽ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Butcher US Senate Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Harhai Mary Russin ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helene Marie Harhai/Wife 3536 Fiske Terrace, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State † Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 11 y 2009 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. John Kla Collus 500 University Blvd., W. Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Alzheimer's Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter I Inderlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

Question 1 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Aspiration Pneumonia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? certificate has the 24a. Was an autopsy performed? Yes 2. No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 A Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2XXNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐Yes 2 ☐ No after death Director: / d in by the f 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Benjamin Avrunin, MD 18111 Prince Philip Drive, Olney, MD 20832 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 10 parke Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0602/ Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Io **Physician** February Helen Dorothy Hill 2009 3:00 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ctr Carroll Lutheran Village Health Care Carroll Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 11 1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F MD 93 Director 213-09-5361 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 USA 200 St. Luke Circle Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic executions. Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Martin Charles Reverdy Tawney 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George Thomas Hill/son 397 Silver Run Valley Rd Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 02/14/2009 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Christ Evangelical Cem Upperco, MD 21. Signature of Funeral Service Incensee Printed Funertadiin Home and Chapel, P.A. V 21157 412 Washington Road Westminster, MD 23a. Pa/1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mishelmes **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to lor as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1∐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

MJL

State Registrar

Columnouta ino

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

D 51705

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. PANSURIVA 349 Malwim DR, Hestminster IMD 21157.

32. Registrar's Signature parker

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			For State Registrar		-	Certificate of			leg. No 2 0 0 9	06028
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	/Medic	cal	Audrey 4a. Facility Name (If not institution, given	Lucille	Har	rington	r Location of Dea	FEBRUAR	Y 12 2009 4c. County of De	
-	Examin	ier	GREATER BALTIM		L CENTER		Location of Dea	ш	BALTIM	
	Funeral Director		213-40-2367	1 - AM-	e (In yrs. last birth	nday) If Under 1 Year Months Days	If Under 24 Hrs Hours Min		, Year) 4,1943 Ma	irthplace (State or Foreign Country) aryland
	laryland show	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Washi	naton	10c. City, Town	or Location rstown				10d. Inside City Limits 1X Yes 2 □ No
	with the Na or 28a-	I Director	10e. Street and Number 22 Mealey Par			10f. Zip Code 217	42		I 0g. Citizen of What C	
36	2 should be filed within 72 hours after death with the Maryland nand Mental Hygjene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent 8 Armed Forces? 1 Yes 2		13. Was Decedent of H If Yes, specify Cub		Specify Yes or No- rto Rican, etc.)	14. Race - An Black, Wh	
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<u>a</u>	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Christina M. Van		I	Mailing Address (Street			-	
ē,	s 1 and if Health item 27 other t		20a. Method of Disposition			Disposition (Name of crematory or other place		Date	20c. Location - City of	
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Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice R. houl Bra	nsee		Andrew K. 140 East And				Md. 21740
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rds, +	iaw requires that the de as been signed by the 2 should be detached	þ	Part II. Other significant conditions	contributing to death bu	ut not resulting in t	the underlying cause giv	en in Part I.			to the cause of death? Probably 4 Unknown
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Division	vttendi death. ctor: A y the fu	icati	2 ☐ Accident investigatio	e lago Place of Inju	urv - At home, farn	M 1 □ n, street, factory, office	Yes 2 □No	28f Location /S	treet and Number or I	Rural Boute Number
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	ne Hosp n 24 ho ne Fune oletely f	Medical			f examination and	death occurred at the ti /or investigation, in my o				
	To the within to the complex c	M	29b. Signature and title of certifier			29c. Licens	6 1886	F	29d. Date signed (Mor	3 . 2009
4	1-16		30 Name and address of person who	completed cause of d	MA A	ype, Print)	KH	10017	a \ 6701 N Towson	. Charles St. , Md. 21204
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		_	For State Registrar		-	Department of F Certificate of		Reg	. No 2009	06029
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All A	/Medic Examin	al	Deborah 4a. Facility Name (If not institution, give	Ann street and number)		Hunter 4b. City, Town, o	r Location of Death	FEBRUARY	10 2009 4c. County of Death	h .
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	and w	Ì	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
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	or 28a	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cou	untry?
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36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, its Modeal Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:)	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
21215-0036	in 72 hou n "natura Adical E	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation		Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of work	ing 16	6b. Kind of Business/I	ndustry
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Baltimore,	permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 Is marked other: any injury or other traumatic event, if once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of cemeter	Disposition (Name of ry, crematory or other place ory of Delma	ce)	Date 20	Oc. Location - City or 1	_
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of Vital Records, P.O. Box 68760,	ng Physician: The law requires that the death certificate be executed after this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as d	e of pregnancy 2 Fetal death at time of death but not resulting ir ient 2 ER/Ou ury ay, Year) 28b. i ijury - At home, fa tc. (Specify)	of): 3	zey ven in Part I. 26. Place of Dearer: 4 □ Nursing H ry at rk?] Yes 2 □ No ime, date and place	1 ☐ Yes 24a. Was an autopsy performs 1 ☐ Yes th (Check only one) 28d. Describe how 28f. Location (Sire City or Town,	Month 24b. Were au prior to codeath? 1 Ves 24b. Were au prior to codeath? 1 Ves 24b. Were au prior to codeath? 1 Ves 24b. Were au prior to codeath? 24b. Were au prior to codeath? 24b. Were au prior to codeath? 25b. Were au prior to codeath. 25b. Were au prior to codeat	ivery Day Year the cause of death? obably 4 □ Unknown topsy findings available completion of cause of 2 □ No cify) ural Route Number,
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of Vital Records, P.O. Box 68760,	ng Physician: The law requires that the death certificate be executed after this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as d	e of pregnancy 2 Fetal death at time of death but not resulting ir cury ay, Year) 28b. 1 ijury - At home, fa tc. (Specify) t of my knowledge of examination artated.	of): a 3	26. Place of Dearer: 4 □ Nursing Hry at tk? I'ves 2 □ No	1 ☐ Yes 24a. Was an autopsy performed at the time, date and autopsy performed at the calculation of the ca	Month 24b. Were au prior to death? 1 Yes 1 Other (Special Post of the Company of the Compa	ivery Day Year the cause of death? obably 4 □ Unknown topsy findings available completion of cause of 2 □ No cify) ural Route Number, s stated. to the cause(s)
of Vital Records, P.O. Box 68760,	ng Physician: The law requires that the death certificate be executed after this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as d	a consequence of pregnancy 2 Fetal death at time of death but not resulting in the consequence of examination are tasted.	of): 3	26. Place of Deaner: 26. Place of Deaner: 4 Nursing Hiny at tk? 27 No lime, date and place opinion, death occurse number	1 Yes 24a. Was an autopsy perform 1 Yes th (Check only one) 28d. Describe how 28f. Location (Stre City or Town, a, and due to the carried at the time, dat	Month Acco use contribute to a 2 No 3 pri 24b. Were au prior to a death? 1 yes Acco 6 Other (Spectaring injury occurred Bet and Number or Russiate) use(s) and manner as te and place, and due d. Date signed (Month	ivery Day Year the cause of death? obably 4 □ Unknown topsy findings available completion of cause of 2 □ No cify) ural Route Number, s stated. to the cause(s) h, Day, Year)
of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as d	a consequence of pregnancy 2 Fetal death at time of death but not resulting in the consequence of examination are tasted.	of): a 3	26. Place of Deaner: 26. Place of Deaner: 4 Nursing Hiny at tk? 27 No lime, date and place opinion, death occurse number	1 Yes 24a. Was an autopsy perform 1 Yes th (Check only one) 28d. Describe how 28f. Location (Stre City or Town, a, and due to the carried at the time, dat	Month Acco use contribute to a 2 No 3 pri 24b. Were au prior to a death? 1 yes Acco 6 Other (Spectaring injury occurred Bet and Number or Russiate) use(s) and manner as te and place, and due d. Date signed (Month	ivery Day Year the cause of death? obably 4 □ Unknown topsy findings available completion of cause of 2 □ No cify) ural Route Number, s stated. to the cause(s) h, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 0 9

		•	for State Registrar		Certificate of D	eath	Reg.	No. 2009	06030
			Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Mary	Evelyn Hut	chison		Feb 6,	2009	9:45 A
	Examin		4a. Facility Name (If not institution, give str		4b. City, Town, or L			4c. County of Death	laamaala
· .			Pineview Nursi		Clinte		9. Date of Righ	Prince G	
	Funeral Director	200		7. Age (In yrs. last bir	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye March	ar) Cour 17,1918 N	slace (State or Foreign stry) laryland
	pu w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location			1	0d. Inside City Limits
	sho	ō	Maryland Prince		inton				1 □ Yes 2 □ No
	28a-1	Director	10e. Street and Number	dediges of	10f. Zip Code		10g.	Citizen of What Cour	ntry?
	Mith With	Ö	8600 Mike Sha	piro Drive #9	2073	5		United S	States
	death	Funeral	11. Marital Status	. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe	cify Yes or No-	14. Race - Americ Black, White,	
320	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It in Madical Earming to profiled a once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2 □ No If Yes, Give \(\) \(1 □Yes 2□No	Specify:	,	Consit II	White
15-0036	"natura	Completed	15. Decedent's Educa (Specify only highest grade	completed)	a. Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired)	tion uring most of workin	168	b. Kind of Business/In	dustry
7	withir ene. than	дшо	Elementary/Secondary (0-12)	College (1-4or 5+)	Administra			Retail	
ם ס	filed Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)				(First, Middle, Mai		
ä	ld be lental ked o	To B	Sabastian T	ennyson		Mary	Ruth Ma	attingly	
ar V	shou and N s mar umat	_	19a. Informant's Name/Relationship (Type	Print Daughter)191	b. Mailing Address (Street a	nd Number or Rura	l Route Number, C	ity or Town, State, Zij	Code)
Ž,	and 2 ealth a 27 i		Dorothy L. Will	iams	7616 Came1	ia Cour			
S S	es 1 a of He fitem		20a. Method of Disposition	20b. Place of cemete	of Disposition (Name of ery, crematory or other place) [[]	ate 200	c. Location - City or To	own, State
altimore,	Pages ment of ant; If its ury or o	Ц	1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		Crematory	Feb 9,	2009 (Clinton,	Maryland
ăait	ermit. Pepart Poort No inj ny inj nce.		21. Signature of Funeral Service Licensee	1/ 1/ 100000	22. Name and Address	s of Facility Le	e Funera	al Home,	Inc 6633
n	90 = 40		(/ Jones O) JAn	nd moods7	01d Alexa	nria Fe	rry Road	l, Clinto	n. MD 207
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do cause on , ach line.	not enter the mode of dying	, such as caldiac o	A D La Da		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	Metastal	ie tholan	20 Ca	neinon		2 Will
	/Medical Examiner		resulting in deathy	Due to (or as a consequence	e of):	otron			ZM
		ē	Sequentially list conditions, if any leading to immediate	Due to (or as a consequence	- 17	CITOR	V		
	uted J Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					1	
<u> </u>	exec in and ial-tra	Exa	that initiated events c. resulting in death) Last	Due to (or as a consequence	e of):				
68760	icate be executed physician and the burial-transit	ical	d.						
89	ng ph as th	Medical	IF FEMALE:						
O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pale 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown				23d. Date of deliving Month	very Day Year
<u>Ч</u>	at the d by ti etach	Phy	9 Unknown Part II. Other significant conditions confi	ributing to death but not resulting	in the underlying cause give	en in Part I.	23e. Did toba	oco use contribute to	the cause of death?
rds,	v requires that the description of spen signed by the should be detached	ed by	Takin. Oaler significant contained con-				1 □ Yes	2 No 3 Pro	bably 4 🗌 Unknown
Division of Vital Records,	e law re has bee	Completed					24a. Was an autopsy performe	d) prior to co	opsy findings available ompletion of cause of
ā	sician: The certificate I rector, paus		25. Was case referred to medical			26. Place of Deat	1 ☐ Yes 2 to (Check only one)	ZNo 1 ☐ Yes	2 🗆 140
5	/sicia s cert directe	o Be	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA Othe			ce 6 ☐ Other (Spec	ify)
9	ding Phys h. After this funeral dir	Ë	27. Myryn r of Death		. Time of 28c. Injury Work		28d. Describe how		
<u>0</u>	ath. rr: Aff	atio	1 Natural 5 Pending 2 Accident investigation	(month) buy, routy		Yes 2□No			
<u>≤</u>	r Atte ter de irecto n by th	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		28f. Location (Stre City or Town,	et a <i>nd Nu</i> mber or Ru State)	ral Route Number,
Ω	urs af urs af ural D		and the second s	ician: To the best of my knowled	lan don't negurred at the tin	no data and place	and due to the car	ise(s) and manner as	stated
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1	ician: To the best of my knowled ier: On the basis of examination a and manner stated.	and/or investigation, in my o	pinion, death occur	red at the time, dat	e and place, and due	to the cause(s)
	ithin (ithin or the or the or the or the	Mec	29b. Signature and title of certifier	A a/	29c. License	e number	290	I. Date signed (Month	, Day, Year)
	F 3 F 0			D - 14/1	India >	2453	55	02 6	909
			30. Name and address of person who co	moleted cause of defail (Item 23s	a) (Type, Prin.)	- 1 /		,	/ /
(BL		Laxmi Berwa, M	7700 014 D		Clinton	, MD 2	0735	<u> </u>
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature					
	Regist	ror	FFR 1 1 20	109 Deneura &	1. Salare				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Ellen Holman D. February 5, 2009 2:48 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2X F 224-32-2029 81 Director 27,1927North Carolina August Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examinational be motified at Director 1 ☐ Yes 2 XNo Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20751 USA 919A Johns Circle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Bace - American Indian Black, White, etc 1 ☐ Yes 2X☐
If Yes, Give
Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify Specify. \$ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Retail Elementary/Secondary (0-12) College (1-4or 5+) Merchandizing Buyer marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) int of Health and Mental H t: If Item 27 is marked oth y or other traumatic even Be Holman Adam Helen McCarthy ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John T. Holman/Brother 2000 Bank Street Baltimore, MD 21231 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages Department of Important: If It any Injury or o 1 Burial 2 Cremation 3 Removal from State 02/12/2009 4 ☐ Donation 5 ☐ Other (Specify) New Bloomfield Cem. New Bloomfield, PA of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home Bowie, MD 20715 6512 NW Crain Hwy. 23a. Part1. Enter the disease, o shock, or heart failure. Lie or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it only one cause on each line. Immediate Cause (Final Physician etastatio disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed for use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. ≥ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Physician: The certificate 2 🗆 No 1∐Yes 2.27No 1 🗆 Yes After this certification, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending Injury n 24 hours after death.

e Funeral Director: A letely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only Within 2. 29b. Signature and cittle of certifie 29c. License number 29d. Date signed (Month. Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Avande OUND Régistrar's Signature 31. Date filed (Month State Registrar

	1 - State Registrar	State of Maryland	Certificate of			g. No.	
Physician /Medical	1. Decedent's Name (First, Middle, Last) Ethel Beatric				Month Februar	y 10 200	9 5:50a. ^M
Examiner	4a. Facility Name (If not institution, give st Chesapeake Woods		,	or Location of Death		4c. County of De.	
Funeral Director	5. Social Security Number 6. Sex 222–24–7844 1□	M 2⊠ F 7. Age (In yrs. las		r II Under 24 Hrs.	8. Date of Birth (Month, Pay, NOV • 10,		inthptace (State or Foreign Country) Ohio
Maryland a-f ehow iffied at	Usual Residence of Decedent 10a. State 10b. County MD Dorchest		Town or Location	ıst New Mar	ket		10d. Inside City Limits 1 Yes 2 No
3a or 28	10e. Street and Number 3619 Secretary East	New Market R	10f. Zip Code	21631	10	og. Citizen of What C USA	Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23e or 28e-1 show any injury or other traumatic event, the Medical Examinar must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Nover 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Sp uban, Mexican, Puerto o <i>Specify:</i>	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
21215-00 ad within 72 hou yajenen ner then "natura ner then "natura ti, the Medical Et, the Me	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti	ne during most of work red)	ing	16b. Kind of Busines educati	
Maryland 21215-0036 d 2 should be filed within 72 hours all the and Mental Hygiene. 77 is marked other then "natural", or traumatic event, the Medical Exam To Be Completed by F	11 17. Father's Name (First, Middle, Last) Wilbur C. Lonis	5+	teacher	18. Mother's Name	e (First, Middle, M a Friedno	Maiden Sumame)	OII
and Men is marke aumatic	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing Address (Stre	et and Number or Run	al Route Number,	City or Town, State,	Zip Code)
Ore, IV of Health of Health item 27	Judy L. Holland 20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3 □ Re		P. O. Box 15 ce of Disposition (Name of metery, crematory or other p	lace)	Date 2	20c. Location - City of	er Town, State
Baltimore, sermit. Pages 1 ar Department of Hea mportant: If item nny injury or othe	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Sal	isbury Cremat	Iress of Facility Th	nomas Fur	Salisbury neral Home	·
n go ∈ € a	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death.	Do not enter the mode of d	st St., Can	or respiratory arre		Approximate Interval Between Onset and Death
68760, titicate be executed as the burial-transit as the burial-transit edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to mmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Congest Due to (or as a conseque Lorona Due to (or as a conseque	rive hear	t faill g dise	ure ase		2 months 10 years
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. II yes, outcome of pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	leath 3 ☐ Ectopic pregnar			23d. Date of d Month	elivery Day Year
rdS, P. Quires that the n signed by uld be detaced by Phy	Part II. Other significant conditions con	tributing to death but not result	ting in the underlying cause	given in Part I.			to the cause of death? Probably 4 □Unknown
The law requirele has been spage 2 should					24a. Was ar autops perform 1 Yes 2	y prior to ned? death?	autopsy findings available completion of cause of ?
ling ling	25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Manner ol Death 1 Natural 5 Pending 2 Accident investigation	T T	28b. Time of Injury 28c. In	Other: 4 Nursing Ho		e) ence 6 □Other (Sp ew intury occurred	pecify)
Division c Division c tel or Attending P rs after death. el Director: Alter t ed in by the funera Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, larm, street, factory, offic		281. Location (Sti City or Town		Rural Route Number,
Divisic To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificat	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin one)	icien: To the best of my know er: On the basis of examination and manner stated.	on and/or investigation, in m	y opinion, death occur	red at the time, da	ate and place, and d	ue to the cause(s)
To the within 2 To the complet	29b. Signature and title of certifier	200	29c. Lice	onse number	3	9d. Date signed (Mo. 2 /10/6	nth, Dey, Year)
6	11 11.	mpleted cause of death (Item)	29c. Lice He 23a) (Type, Print) Bram	ble (2 ambr	idse p	10
State Registrar	31. Date filed (Month, Day, Year) FEB 11 200	32 Aegistrar's Signatu	. Sall			0	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Reg. No. 20 06033 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 2089 Day 55 CKLER 2 7 7 10 4a. Facility Name (If not institution. give street and number) Town, or Location of Death 4c. County of Death AUTIMORE OSPLTAL 8. Date of Birth (Month, Day, Year)
Dec. 29, 1935 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🗓 F Months Days Hours Min 218-32-3729 73 Yrs. Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location New Freedom 1 ☐ Yes 2 No York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17349 U.S.A. 1648 Sweitzer Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐Yes 2 XNo Specify Specify: White 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Transportation Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret S. Blouse Wilmer Earl Cummings

> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2300 Garrett Rd. White Hall, MD 21161

> > Date

Second St., New Freedom, PA 17349

RAUTINORE MA

Feb. 24,

2009

20c. Location - City or Town, State

J.J. Hartenstein Mortuary, Inc.

Month

Shrewsbury, PA 17361

Approximate Interval Between Onset and Death

Year

0

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 No

1 ☐ Yes

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Experience must be notified at and 2 should be filed within 72 hours after death with Baltimore, Maryland 21215-0036 tal Hygiene. Menta if Health and Ments Item 27 is marked permit. Pages 1 a
Department of He
Important: If Item
any injury or othe

Physician

/Medical

Examiner

10a. State

PA

Funeral

Director

28a-f show

Director

Funeral

Completed by

Be

٩

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

Signature of Funeral Service License

20a. Method of Disposition

Judy Garrett, Daughter

1 Burial 2 □ Cremation 3 Nemoval from State

the Maryland

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and sbeen signed by the attending physician should be detached for use as the burial certificate has page 2 s this funeral After ours after death.

neral Director: A
filled in by the fu To the Hospital within 24 hours a To the Funeral C

P.O. Box 68760.

of Vital Records,

23a. Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 000 disease or condition resulting in death) Due to (or as a consequence of) O Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine 102 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 ANo
9 Unknown 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 Yes 2 No 3 Probably → Unknown Completed 24a. Was an autopsy perform 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA ۵ 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 2 Accident (Month, Day, Year) 5 Pending investigation 1 Tyes 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier

20b. Place of Disposition (Name of

cemetery, crematory or other place) Christ Evangelical Lutheran Cemetery

24

22. Name and Address of Facility

State Registrar Year)

5

31. Date filed (Month, Day,

30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)

3



DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene A 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1:45 February 06 2009 Gladys Blanding Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12909 Tamarack Road Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F **Director** 147-24-9282 91 April 25, 1917 North Carolina Usual Residence of Decedent 12 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. This marked other than "tratural", or items 23a or 28a-f show traumatic event, the Medical Exercities must be notified at traumatic event, the Medical Exercities results of an expension of the statements. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2 K No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12909 Tamarack Road 20904 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces 1 Never Married 2 Married 1 ∐Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: African-American δ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Healthcare Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin Davis Dora Dimery မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 of Health William R. Jones-Son 12909 Tamarack Road, Silver Spring, Maryland 20904 item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition = 5 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o important: If any injury or once. 4 Donation 5 Other (Specify) Gate of Heaven Cemetery | 02/12/2009 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New_Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the dise shock, or heart failur ise, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Find disease or Condition Physician End Stage Dementia Months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the detached i 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by icate has been signated by page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 1 □Yes 2 🖺 No Division of Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. after death Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Direstructures of the control of the contr 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D41978 February 10, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nader Tavakoli, M.D., 4000 Mitchellville Road, Suite A-312, Bowie, Maryland 20716 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 11 Registrar

	1 - State Registrar			olale 0	iviaiy	land / D		icate o				Reg. No		9	0603
cian	1. Decedent's Name (Firs		e, Last)								2. Date of De Month	Day		Year 009	3. Time of Deat
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	14005 BLAZ 5. Social Security Number		6. Sex		7. Age (In	yrs. last birt	hday) If	Under 1 Yea	ar If Unc	ler 24 Hrs.	8. Date of Bi				place (State or For
1	216-74-0276 Usual Residence of Dece			1 2□ F	67	-	rs. Me	onths Day	/s Hour	s Min.	8. Date of Bir (Month, Date AUGUST	ay, Year) 27]	NORT	H CAROLI
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by F	1 Never Married 2 3 Widowed 4 □ D		ried	1 ∐Yes If Yes, Gi Year or D	ve		1 🗆 '	Yes 2 K ∫N	lo <i>Sp</i> ec	ify:			Specify:	BLA	CK
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2	SILAS JONE	S							MY	RL .	JONES				
	19a. Informant's Name/R	elations	hip (Type	Print)			J				al Route Numb				. ,
	NAPOLEON JO		BROT	HER_		12	104 E	BLAKET	ON ST						LAND 207
	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cres		3 ☐ Ren	noval from	State 2	Ob. Place of cemeter				1	Date			•	wn, State
	4 □ Donation 5 □ C	Other (S	pecify)			RIVER								-	RYLAND
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785												20785		
	23a. Part 1. Enter the dish se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate interval Between														
И	shock, or heart failu Immediate Cause (Final	e. List	only one	cause on e						ao caraiao	or reopiratory t	arroot,			Interval Between Onset and Death
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Examiner	Cause (Disease or injury that initiated events	-	c.												
Ä	resulting in death) Last			Due to	(or as a co	nsequence o	f):								
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ian	23b. Was decedent pregr in the past 12 month		230	1 Live		Fetal death		topic pregna				2	23d. Date Mont		ery Day Year
ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown			9 ☐ Unkr	nant at tim nown	e of death	5 LI Oti	her (specify							
Phys	Part II. Other significant	conditie	ons contri	buting to d	eath but no	ot resulting in	the under	lying cause	given in Pa	rt I.	23e. Did	tobacco u	se contrit	bute to th	ne cause of death
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

06036

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 □Yes 2 No

Washington

St. Mary's

USA

Month

Day

1 ☐ Yes 2 ☐ No

Year

10:10 P M

1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 14, 2009 James Lee Johnson February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 45713 Summer Lane Lexington Park 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Min 46 218-74-3227 Director February 4, 1963 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Motical Examiner must be notified at Director Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45713 Summer Lane 20653 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ☑Yes 2 ☐ No and 2 should be filed within 72 hours after teath and Mental Hygiene. m 27 is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2X No If Yes, Give Year or Dates Specify. ģ 3 ☐ Widowed 4 🖾 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Automobile Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ronald Lee Johnson Betty Ann Shegogue 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Ann Johnson / Mother 45713 Summer Lane Lexington Park, MD 20653 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 tment of h 20a. Method of Disposition February 19, permit. Pages
Department of
Important: If it
eny injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Leonardtown, Maryland Charles Memorial Gardens 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 23a. Part 1. Enter the disease, or con shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed be used the constitute of each.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit each. as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Other significant fonditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ■Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4 ☐ Nursing Home 5 █ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 😡 Natural 5 ☐ Pending investigation 2 🗌 No 1 ☐ Yes 2 Accident 6 ☐ Could not be To the Hospital or Atter within 24 hours after ded To the Funeral Directo completely filled in by th 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) D31952 February 16, 2009

Registrar

30. Name and address of person who complete

17

22576 MacArthur Blvd

31. Date filed (Month, Day, Year)

fornia, MD 20619

Registrar's Signature

use of death (Item 23a) (Type, Print) Michael Szkotnicki, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** p^{M} February 2009 Shirley L. Kranz 5:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Mont. Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Year) Days Min. 1 □ M 243XF Hours 142-18-5899 Mar 16, Director 84 1924 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examinate met an instrument to nother traumatic event, It a Medical Examinate met an other traumatic event. Director 1X Yes 2 No MDMont Silver Spring MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code # 311 3128 Gracefield Rd. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 22 Married ☐Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No if Yes, Give Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Mgr. Balt. Sun 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (2 Abraham Lipnick Anna Fox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Kranz - Husband 3128 Gracefield Rd. #311 Silver Spring MD 20904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State King David Mem. Grdn 2/9/09 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA 21. Signature of Funeral Service I 22. Name and Address of Facility Edward Sagel Funeral Direction Inc. Donald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** a Clostridium difficile enterocolitis disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) o the 1 ☐ Yes 2 No 9 Unknown ģ detacl σ. s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy certificate I perform 1 □Yes 2 X No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this c 1∐ Yes 2 No 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred 1 🔀 Naturai 5 Pendina within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) February 7, 2009 D0036716 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver Spring MD 20904 Andrew Kundial M.D. 3110 Gracefield Rd State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** Richard Kramer Kelly February 2009 9:05 A W 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sykesville Carroll County Transitions Healthcare 8. Date of Birth (Month, Day, Yea If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1932 **Funeral** 1⊠M 2□F Days Hours Months 212-38-0451 76 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, Ite Medical Evanment must be not the event once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Carroll County Westminster 1 □Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3428 Sykesville Road 21157 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No white Specify: Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 10 College (1-4or 5+) stationary engineer State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Ethel Kramer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3428 Sykesville Road Westminster, Maryland 21157 Betty Ruth Kelly - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Feb. 2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🗷 Other (Specify) Fin Combinent Finksburg, Maryland Evergreen Memorial Cons. Fline Funeral Home 22. Name and Address of Facility Signature of Funeral Service License M01072 934 South Main Street Hampstead, Maryland 21074 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b irector, page 2 s 24a. Was an autopsy perform 2 **DN**0 1 ☐ Yes 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated. 29b. Signatu 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day,

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year,

09

		•	For State Registrar	State of Ma	aryland /		artmen rtificat			d Mental Hy	/giene	09	06039
ents.	Physici /Medic		1. Decedent's Name (First, Middle, Last, Robert I. Kauffm							2. Date of De Month Feb.		2009	3. Time of Death 20:45 P M
(Examin		4a. Facility Name (If not institution, give Harford Memorial	Hospital	-		Havr	e de	Location of D Grace		Н	nty of Death arford	
	Funeral Director		5. Social Security Number 6. Set 193-20-5681	7. Ag 【M 2□F	e (in yrs. last i	Yrs.	If Under Months		Hours	Vin. (Month, D.	ith ay, Year) 3, 1926	9. Births Coul Penn	place (State or Foreign ntry) sylvania
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show eny injury or other traumatic event, It a Madical Exact in arminities notified at once.	erai Director	10a. State 10b. County Maryland Cecil 10e. Street and Number 246 New Valley R			nowi	ngo 10f. Zip	219				of What Cou	
9000	hours after de turel', or Item	ed by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 15. Decedent's Edu	12. Was Decedent Armed Forces? 1 ZYes 2 1 If If Yes, Give Year or Dates:	WWII		1 ☐ Yes	2 ½ No	Specify:	? (Specify Yes or No uerto Rican, etc.)	Spec		etc. ite
Maryland 21215-0036	iled within 72 tygiene. her than "nat nt, if e Me dic	Completed	(Specify only highest grade Elementary/Secondary (0·12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5	o+)		kind of wo. DO NOT us	her	tion uring most of	working Name (First, Middle		Printi	,
arylanc	should be f and Mental I marked of urnatic ever	To Be	Irvin Jesse Kauf 19a. Informant's Name/Relationship (Ty		11	9b. Mailir	ng Address		Edna	Knox r Rural Route Numb		,	Code)
Baltimore, M	ages 1 and 2 int of Heelth a t: If Item 27 is y or other tra		Janis Peters 20a. Method of Disposition 1	emoval from State	20b. Place ceme	of Dispo tery, crea	sition (Nan natory or o	ne of ther place)	Conowingo Date -17-2009	20c. Locatio		
Baltin	permit. P Depertme Importani eny injury once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Cens	90	Arli	22	n Cemeran R.T. 111 S	d Address Foar	of Facility d Fune	ral Home,	P.A.	- 352	, PA 19026 911
760,	Physician /Medical Examiner portional-transit	icai Examiner	23a ant. Enter th disease, or composhock, or hin failure. List only immediate Cadse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence a consequence	e of):	er the mod	e of dying	, such as car	diac or respiratory a	arrest,		Approximate Interval Between Onset and Peath
.O. Box 68	Attending Physician: The law requires that the death certificate it death. r death. ector: Atter this certificate has been signed by the attending physis py the funeral director, page 2 should be detached for use as the b	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		Ectopic pr Other (sp					Date of delive	ery Day Year
ords, P.	equires that en signed b ould be deta		Part II. Other significant conditions con	ntributing to death b	ut not resulting	in the u	nderlying c	ause giver	n in Part I.		tobacco use co		he cause of death? pably 4 Unknown
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Division of Vit	To the Hospital or Attanding Physician: The law requires that the de within 24 hours eliter death. To the Funeral Director: After this certificate has been signed by the icompletely filled in by the funeral director, page 2 should be detached	Certification: To Be	27. Mann of Death 1 Watural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		Outpatier Time of Injury		8c. Injury Work	. 4 🗍 Nursir	Death Check only ng Home 5 Res 28d. Describe			(y)
DIX	ospital or Att hours efter d uneral Direct ly filled in by	ai Certifi	4 Homicide determined 29a. Certifier 1 Certifying Physics	28e. Place of tnj building, et sicien: To the best	c. (Specify) of my knowled	qe, deat	h occurred	at the time	e, date and p	City or To	own, State)	manner as s	al Route Number,
	To the Hospital or within 24 hours efte To the Funeral Dir completely filled in I	Medical	29b. Signature and life of certifier	and manner sta	f examination and all all all all all all all all all al	and/or in	vestigation,	in my opi	nion, death o	occurred at the time.	, date and place 29d. Date sign	e, and due to	o the cause(s)
	5 Sta Registr		30. Name and address of person who co	AD MD	leath (Item 23a		PPER	. 4	he sape	ake Dr	Bel A	JN M	04014

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DHMH 17 Rev 1/2001

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	-	For State		:	State o	f Mai	ryland		artme ertifica				ental Hy	giene Reg. No	$2 \mathrm{H}$	09	060	040
		Registrar Decedent's Name	(First, Middl	e, Last)									2. Date of De	eath			3. Time of	f Death
Physicia		Seymour	Lish	noff								F	Month 'ebruar	v 7		Year 2009	6:53	р ^M
/Medic		4a. Facility Name (If				m <i>ber)</i>			4b. City	, Town, or	Location	n of Death				of Death	1000	P
_xa	À	Suburban	Hospit	:a1					Beth	esda					Mon	tgome	erv	
Funeral		5. Social Security No		6. Sex	M 0D 5	7. Age	(In yrs. la	st birthdaj		r 1 Year	If Unde	er 24 Hrs. Min.	8. Date of Bi (Month, D	rth a <i>y, Y</i> ea <i>r)</i>			place (State	or Foreign
Director		052-16-02		1X	M 2□F	90		Yrs.					May 27		18	New	York	
MC #		Usual Residence of 10a. State	10b. County			- 1	10c. City,	Town or L	ocation.							1	I 0d. Inside C	ity Limits
-f sh	to	MD	Montgo	merv	7		D - +1	nesda									1 ★ Yes	2 🗆 No
r 28a	Director	10e. Street and Num					Deti	iesga	_	p Code				10g. Cit	izen of	What Cour	ntry?	
23a o		4925 Batt	ery L	ane					20	814				U.S	S.A.			
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or it	by Fu	1 Never Marrie			1 ☐Yes If Yes, Giv	2⊠No ve)		1 □Yes		Specif		,			y: Whi		
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tealth m 27 her tr		Marilyn I		<u> </u>	aught	er	Logi, Di						thesda			17 - City or To	Chata	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar is ust be nother any once.		20a. Method of Disp 1 X Burial 2	Cremation		moval from	State			oosition (Na ematory or 1em •		:e)	2/9/0			ey,	-	JWII, State	
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Medical		disease or condition resulting in death)	n	Ta.			consequ											
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signe d be o	d b									3			1 🗆	Yes 2	□ No	3 ☐ Prol	bably 4 🛒	Unknown
been	eted												24a. Wa	s an	24h	Were auto	opsy findings	available
e has	Comple												auto	opsy ormed?		prior to co death?	ompletion of	cause of
tificat tor, pa		25. Was case refer	red to medica	ıl							26 Pla	ce of Death	1 ☐ Yes (Check only)	1 □ Yes	2 ∐No	
is cer direct	To Be	examiner? 1 ☐ Yes 2 🙀	No	Ho	spital: 1K	Inpatien	nt 2 🗆 E	ER/Outpat	ent 3 □ [Oth	or:		ne 5 Res		6 □Ot	her (Speci	ifv)	
ter th		27. Manner of Deat	h 5 □ Pendi		28a. Date	of Injury	y Year)	28b. Time Injury		28c. Injur	y at		28d. Describe					
or; At	atic	1 Natural 2 Accident	invest	gation		, ,,,			М		Yes 2[□No						
fter de irect n by t	Certification	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could deterr		28e. Place build	e of Injur ling, etc.	ry - At hor (Specify	me, farm, s	street, facto	ry, office		1	28f. Location City or To	(Street ar wn, State	nd Num e)	ber or Rur	al Route Nur	nber,
eral C		29a. Certifier	1+7 Cartifui	na Dhyei	ician: To the	e beet of	f my knou	vledae do	oth occurre	d at the ti	mo data	and place	and due to th	o causale	n bac (e	nanner as	stated	
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one)				pasis of	examinat						ed at the time					s)
within To the compl	Me	29b. Signature and	title of certific	741	1,,	100	EA	10	2	9c. Licens	e numbe	r		29d. Da	te sign	ed (Month,	Day, Year)	
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>		30. Name and addr	ess of persor	who con	npleted caus	se of de	ath (Item	23a) (Typ	e, Print)									
		Gary E.			. FACI	P 1	1119	Rock	ville	Pik	e #3	16 Ro	ckvill	e MD	208	352		
Sta Registr		31. Date filed (Mon	B 11	2009	3	negistra	rs Signat	ure	wid									
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Regist DHMH 17 Rev 1/2001

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Modical Examinational be putflied at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

		For State	State of Maryla		partment of h ertificate of		Mental Hy	/giene Reg. No	711119	06041
		Registrar 1. Decedent's Name (First, Middle, La	ıst)		or imouto or		2. Date of D	eath		3. Time of Death
Physicia		Gifford	l Edmund Hui	rd Lav	son		Februa	.rv 8	*	7:00 P. M
/Medic		4a. Facility Name (If not institution, gi				or Location of Dea		_	. County of Deat	
./		Shady Grove Adver	ntist Hospita	1	Rockvi				lontgome	ry
Funeral		,	157M 2□ E	rs. last birthda	Months Days	If Under 24 Hr Hours Mir) (Month, D	irth a <i>y</i> , Year)	9. Birt	hplace (State or Foreign untry)
Director		422-14-8932 Usual Residence of Decedent		98 Yrs.			Aug. 2	5, 1	910 Mass	sachusetts
fand	ŀ	10a. State 10b. County	10c.	City, Town or	Location					10d. Inside City Limits
Mary	to	Maryland Montgo	merv	Montgo	mery Villa	age				1 ∐ Yes 2 🕱 No
h the	Directo	10e. Street and Number	mczy	11011250	10f. Zip Code			10g. Cit	tizen of What Co	untry?
th wit		18700 Walkers Cho	oice Road, #	101	208	86		Ur	nited St	ates
-UU.30 hours after death with the Maryland tural", or items 23a or 28a-f show al Evan incrinet be northed at	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 1:	 Was Decedent of F If Yes, specify Cub 	lispanic Origin?	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Ame Black, White	
S afte	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ∏Yes 2 No If Yes, Give		1 □Yes 2 🖾 No	Specify:			Specify:	Th-1 + a
5-UU-36 72 hours aft natural", or		15. Decedent's E	Year or Dates:	16a. De	cedent's Usual Occup	pation		16b. K	ind of Business/	hite Industry
in 72 in 72 in 72 in 40 in 40	Completed	(Specify only highest gr	ade completed)	(Gi	ve kind of work done . DO NOT use retire	during most of w	orkin g			,
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al Hys	Be C	17. Father's Name (First, Middle, Las.	0			18. Mother's Na	ame (First, Middle	e, Maiden	Surname)	
Viand build be file Mental Hi arked oth atic even	20	Gifford	Hazell Laws	on			Mary	Mari	ia Hurd	
Mar d2 sho tth and traum: traum		19a. Informant's Name/Relationship								Zip CodeMD . 20886
e, IV 1 and Health 9m 27 ther tr		Mary H. Lawson/Da								ery Village
ges 1	,]	20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐	→ Hemoval from State		position (Name of rematory or other pla		Date		ocation - City or	
Baltimo Dermit. Pages Department of mportant: If II any Injury or once.		4 □ Donation 5 □ Other (Special			itan Crem					Virginia
DEBILITIONE, MISTYISHING Z.I.Z.I.5-UU.50 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Modical Examination or other traumatic events.	C.	21. Signature of Funeral Service Lice	nsee /	1/4	22. Name and Addre	_				m 20077
		23a. Part 1. Enter the disease, or con	onlications that caused the d		O East De				sburg,	Approximate
Div1.1-		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.				,			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cons	-	ance/					months
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	Me	IF FEMALE:	23c. If yes, outcome of pre-	anancy					00 d D-44 d-1	
OT VITAL RECORDS, F.O. BOX of Physician: The law requires that the death certificate has been signed by the attending ral director, page 2 should be detached for use as	sician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time	etal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су			23d. Date of del Month	Day Year
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that hed by deta	by Phy	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause giv	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
guires							1 🗆	Yes 2	□ No 3□ Pr	obably 4 Unknown
ecords law requires as been sigr	Completed						24a. Wa		24b. Were au	topsy findings available
The late has bage 3	E						- auto peri 1 □ Yes	opsy formed? 2 \int No	death?	completion of cause of 2 □ No
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OT V Physic	2	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	□ ER/Outpat	tient 3 DOA Oth	ner: 4 🗆 Nursing	Home 5 ☐ Res	sidence	6 ☐ Other (Spe	cify)
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SIO tendi eath, for: A	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not to				Yes 2□No				
JIVISION I or Attending after death, Director: Afte	Certification:	4 Homicide determined		t home, farm, ecify)	street, factory, office		28f. Location City or To	(Street ar wn, State	n d Numbe r or Ru e)	ural Route Number,
pltai purs a eral I		29a, Certifier 1 Certifying P	hysicien: To the best of my	knowledge de	ath occurred at the t	ime date and pla	ice and due to th	0 031180/8	s) and manner as	s stated
DIVISION OF VITAL HER WHILE A HOSPITAL OF Attending Physician: The law within 24 hours after death, To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check only 2 Medical Exe	miner: On the basis of exam and manner stated.	nination and/or	r investigation, in my	opinion, death oc	curred at the time	e, date an	d place, and due	to the cause(s)
To th Vithir Comp	Me	29b. Signature and title of certifier	0		29c. Licens	se number		29d. Da	ate signed (Monte	h, Day, Year)
10		· //	~ John	~	D.	2014	8	Fc	spinson o	2009
		30. Name and address of person who	completed cause of death (I	1tem 23a) (Typ	Print)	Ave	Gather	sbur	, md	. 20879
Star Registra	le ar	31. Date filed (Month, Day, Year)	2009 32. Fégistrar's Signera	gnature 8. /4	pares					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3:15 p^M February Leslie Roy Lambert, Jr 4c. County of Death 4a. Facility Name (If not institution, give street and number) Ctr 4b. City, Town, or Location of Death Carroll Westminster Carroll Lutheran Village Health Care If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day,) Sept 30 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Year) 1913 1**⊠** M 2□ F 214-16-1626 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Nes 2 No Carroll Westminster MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 200 St. Luke Circle 21158 14. Race - American Indien. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White Specify: 3KWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) State Highway Adm Foreman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virgie Malana Lindsay Leslie Roy Lambert, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4102 Clagett Road Hyattsville, MD Kimberly Nugent/niece 20b. Place of Disposition (Name of cemetery, crematory or other place Cem.) 20c. Location - City or Town, State 20a. Method of Disposition ► Burial 2 Cremation 3 Removal from State Ebenezer Methodist CH 2/15/2009 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pritts Attitle Fally Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. P. r/1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. This only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown

To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit Division or Vital Records, P.O. Box 68760,

Physician /Medical

Examiner

Examiner

Physician/Medical

Completed by

Medical Certification: To Be

Physician

/Medical

Examiner

Director

þ

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

WJZ 10

	9 □ Unknown							
Pa	rt II. Other significant condition	ons cor	ntributing to death but not resi	ulting in the underlyin	g cause given ir	Part I.	23e. Did tobacco	use contribute to the cause of death? No 3 □ Probably 4 □Unknown
_							24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 21 No
25	. Was case referred to medical				26	. Place of Death	(Check only one)	
	examiner? 1 Yes 2 No	F	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other:	Nursing Hom	e 5 Residence	6 ☐Other (Specify)
27	. Manner of Death Danatural 5 Pendin Accident investig		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes		8d. Describe how inju	ary occurred
	3 ☐ Suicide 6 ☐ Could determ		28e. Place of injury - At he building, etc. (Specif	ome, farm, street, fac	tory, office	28	Bf. Location (Street at City or Town, State	nd Number or Rural Route Number, e)
29	Pa. Certifier (Check only 2 Medical	ng Phy Exami	sician: To the best of my kno iner: On the basis of examina	owledge, death occur ation and/or investiga	red at the time, tion, in my opini	date and place, a on, death occurre	nd due to the cause(sed at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)

29b. Signature and title of certifier DR. E. Walden MU

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeath (Item 23a) (Type, Print)
300 ST. Luke CIRCLE WESTMINSTER, Md. 24158 31. Date filed (Month, Day,

State Registrar 32. Registrar's Signature Deneur

		1	For State Registrar	State o	f Maryland / De <i>C</i>	partment of He ertificate of D			iene _{eg. No.} 0 (9	06043
			Decedent's Name (First, Middle	e, Last)				2. Date of Dea Month	Day	Year	3. Time of Death
	Physicia /Medic	al	Mary Lutz					Feb	07	2009	4:05 AM M
	Examin		4a. Facility Name (If not institution	n, give street and nur	mber)	4b. City, Town, or L			4c. County		
			Long View Nursing 5, Social Security Number	Home 6. Sex	7. Age (In yrs. last birthda	MAnche (av) If Under 1 Year	ester If Under 24 Hrs.	8. Date of Birth	Carro	9. Birthi	place (State or Foreign
	Funeral Director		220–22–6798	1 □ M 2/□ F	81 Yrs.	Months Days	Hours Min.	Aug. 4,	1927	Penns	ylvania
			Usual Residence of Decedent								10d, Inside City Limits
	nylan show		10a. State 10b. County		10c. City, Town or	Location					1 ☐ Yes 2 ☒ No
	8a-f	Funeral Director	PA Yor	`K	Hanover	10f. Zip Code			10g. Citizen of	What Cou	ntry?
	with the	Dire	10e. Street and Number	•		17331			_	SA	,
	eath v	erai	4 Valley Run Circl	12 Was Dec	edent Ever in U.S. 1	3. Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp	ecify Yes or No-		ce - Ameri	can Indian,
"	r iten	표	1 ☐ Never Married 2 ☐ Mar	Armed Fo	2 🕅 No	1414	Specify:	Hican, etc.)	Speci	ick, White,	ite
93	ral', o	l by	3XXWidowed 4 □ Divorced	If Yes, Gir Year or D	ates:						
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f show the Madical Examiner must be notilliad at	Completed by	15. Decedel (Specify only highe	nt's Education est grade completed)	16a. De (G	icedent's Usual Occupat ive kind of work done du e. DO NOT use retired)	tion uring most of work	ring	16b. Kind of E	susiness/ir	ndustry
121	within	ig I	Elementary/Secondary (0-12)	College (1-4or 5+)	erator			Teleph	one Co	mpany
d 2	filed Hygie other		17. Father's Name (First, Middle	Last)			18. Mother's Nam	e (First, Middle,	Maiden Suma	me)	
an	lid be lental ked c	To Be	John Skunda				Ellen Ho				
Maryland	shou and N s mai	-	19a. Informant's Name/Relation	ship (Type, Print)		ailing Address (Street ai				, State, Zi	p Code)
	and 2 saith a n 27 i	1 2	Stephanie E. McSw	eeney - Daug		alley Run Circ		er, PA 173 Date	31 20c. Location	- City or T	own State
ore	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 XRemoval from	State	sposition (Name of crematory or other place					OWII, State
Baltimore,	Pag tment tant: jury o		*4 □Donation 5 □ Other (Specify)	York Road	Cemetery 22. Name and Address	2/10/		HAnover	•	inc
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural; or Items 23a or 28a-f show important: If Item 27 is marked other then "natural; or Items 23a or 28a-f show important or other treumstic event, the Madical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	- cco354	269 Frederi					
760,	Physician /Medical Examiner be prize and prize prize and prize prize and prize prize and prize	cai Examiner	23a. Part 1. Enter the dilease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	(or as a consequence of)	ender Oc	2.0				Interval Between Onset and Death
.O. Box 687	te death certifica the attending ph hed for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	utcome of pregnancy birth 2 Fetal death gnant at time of death nown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		177	1	Date of deli Month	very Day Year
<u>α</u>	uires that th signed by kd be detac	b	Part II. Other significant condi	tions contributing to	death but not resulting in t	ne underlying cause give	en in Part I.	23e. Did t		ntribute to	the cause of death?
Records,	The law requirence to the has been sinage 2 should I	Completed						24a. Was autoj perfo		prior to death?	topsy findings available completion of cause of
Vital	ysicien: The l is certificate ha director, page	Be C	25. Was case referred to medic examiner?				26. Place of Dea		The same of the same of		
of V	Physic this ce al dire	P	1 ☐ Yes 2 No		Inpatient 2 ER/Outp		4 Z Naursing F	lome 5 🗆 Resi 28d. Describe			pify)
u C	ding Ph h. After th funeral	inol in	27. Manner of Death 1 Matural 5 ☐ Pend	inig	a of Injury nth, Day Year) 28b. Tir Inj	ury Work	k? Yes 2□No	200. 20001100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Division	or Attending ter death. irector: After n by the fune	Certification:	3 ☐ Suicide 6 ☐ Coul	minod 280, Plat	ce of Injury - At home, farn ding, etc. (Specify)			28f. Location (City or To	Street and Nui wn, State)	mber or Ru	ıral Route Number,
Ω	To the Hospitei or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	edicai Ce	29a. Certifier 1 Certify (Check only one)	al Examiner: On the	ne best of my knowledge, basis of examination and	death occurred at the time of investigation, in my of	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certi		4	29c. License	e number		29d. Date sig	ned Monti	h, Day, Year)
	- sto		X La da a la	1 Phol	lita var	1 15.	5443		219	1/2	009
1	all I		30 Nam and address of person	on who completed ca	use of death (Item 23a) (T	9 . 8	<1	1.			2011
	10		J. Unw. M.	dd/etm	m D 3337	retory -	Treet	Man	chest	21,1	n,) 21102
	S [.] Regis	tate trar	31. Date filed (Month, Day, Yell FEB 1 0	2009	Registrar's Signature	arked	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:17 P.M Thomas Mathis, Jr. February 5, 2009 Coy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville
If Under 1 Year | If Under 24 Hrs. Montgomery <u>Shady Grove Adventist Hospital</u> 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Months Director <u>239-36-5336</u> 15, 1928 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 ☐ Yes 2 🔯 No Maryland| Montgomery <u>Gaithersburg</u> 10e. Street and Number 10g. Citizen of What Country? Funeral 28724 Greenberry Drive 20882 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Modical Eventrants once. 1 RYes 2 No 1946-1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced 1949 Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Bricklayer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Coy Thomas Mathis, Sr. Fannie Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace L. Mathis/Wife 28724 Greenberry Dr., Gaithersburg, Maryland 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/11/2009 Souls Cemetery Germantown, Maryland 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician a. Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Metastatic Cancer (Unknown Primary) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Chronic Kidney Disease resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 🔯 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ARSHAD FEBURARY 05 2009 JAWAD M.D DOO 674 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jawad Arshad, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Genevieve Natalie McDermitt January 30, 2009 2:25 a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 □ M 2 🌣 F Months Days Hours Min. 158-16-7225 89 Director Oct. 20, 1919 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ed other than "natural", or items 23a or 28a-f sho event, the Wedless Examinal must be notified at 1 Yes 2 No Director 28a-f Maryland Montgomery Takoma Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8000 Wildwood Drive 20912 USA items 23a Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Specify: White ρ 3₺ Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h pe Santo Gallo Rose Iuzzi thand 2 should by Health and Ment tem 27 is merked ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Professor E. V. McDermitt/Son 10225 Frederick Avenue, #516, Kensington, MD 2089 permit. Pages 1 and Department of Health Important: If item 27 eny injury or other ti 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National 4 ☐ Donation 5 ☐ Other (Specify) March 3, 2009 Cemetery Arlington, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Unsease or injury Due to (or as a consequence of): Exami that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): MHL (Chevillate 1150/logical Vital Records, P.O. Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ed by the detached i 1∐Yes 2**★**No 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autops this certificate 1X Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 TNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred i or Attending F Division 5 Pending investigation t Natural 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 30, 2009 D26259 10 30. Name and address of person who completed cause of death (Mem 23a) (Type, Print)

Ava Kaufman, MD 8218 Wisconsin Avenue, Bethesda, MD 20814 Ava Kaufman, MD 32. Begistrar's Signature State Registrar

			1 _ State	partment of Health and ertificate of Death	, ,	0000	0501.5
			Registrar 1. Decedent's Name (First, Middle, Last)	or impact or boarn	2. Date of Death	1. No 2 U U 9	3. Time of Death
	Physici		Philip Sidney Morgan, III		Month February	8, 2009	7:55am M
	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death	7.JJan
_			Montgomery General Hospital	Olney		Montgomery	7
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd.	Months Days Hours Min.		9 Birthr	lace (State or Foreign
	Director		224-38-5062 TAX M 2 F 75 Usual Residence of Decedent				land
	land ow		10a. State 10b. County 10c. City, Town or	Location		1	0d. Inside City Limits
	Mary Frsh	ţ	Maryland Montgomery Brookey	ri 11e			1 □Yes 2 No
	or 282	Director	10e. Street and Number	10f. Zip Code	100	J. Citizen of What Cour	ntry?
	th wit		19544 Dubarry Drive	20833	U	nited State	28
	ems	Funeral		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - Americ Black, White,	can Indian,
30	hours after death with the Maryland tural", or Items 23a or 28a-f show al Exercity count by notified at	by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	1 ☐Yes 2 ☑ No Specify:	, ,	Specify: Wh	
Ş	hour tural		3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. De	cedent's Usual Occupation	14	6b. Kind of Business/Inc	
5	in 72 n "na	Completed	(Specify only highest grade completed) (G	ive kind of work done during most of wor e. DO NOT use retired)	rking	bb. Killa of Basilless/III	dustry
7 7	d with giene	E	Elementary/Secondary (0-12) College (1-4or 5+) 4 Ag	ency Owner		Insurance	
<u> </u>	al Hy I othe vent,	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nar	ne (First, Middle, Ma	iden Surname)	
<u>X</u>	Ment Ment arked	2	Philip Sidney Morgan, Jr.	Harriet	Wannamak	er	
Maryland 21215-0036	2 sho and is m raum			ailing Address (Street and Number or Re			
a) a)	l and Health			5 E. Lake BLuff Bl			
وّ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is marked other than "natural", or items 23a or 28a-f show am injury or other traumatic event, the Medical Experiment or per public of an once.		TE Bullar 2 La Cremation 3 El Remova nom State	sposition (Name of rematory or other place)		c. Location - City or To	wn, State
Baltimore,	nit. Pa artme ortani Injury		4 □ Donation 5 □ Other (Specify) Metropo 21. Signature of Eugeral Service Licensee	litan Crematory 2 22. Name and Address of Facility De	/9/09 A:	lexandria,	Virginia
ä	permi Depar Impo any Ir		1-1-4/1 n 1/1/	10 East Deer Park Gaithersburg, MD 2	Drive	ar nome	
П			232. Part 1. Ent at the disease, or complications that caused the death. Do not			t,	Approximate
	Physician		shock, or neart failure. List only one cause on each line. Imm. High Cause (Final disease or condition and creatic Cance)	_		1	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Pancreatic Cance Due to (or as a consequence of):			L	ays
	Examiner		Sequentially list conditions b.				
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course (Use of their parts) that initiated events c.				
	execut and al-tran	Examine	that initiated events resulting in death) Last C				
8/6U	ficate be executed physician and s the burial-transit	dical E					
80	tificat ig phy as the	edic	u.				
X R R	h cer endin	M/us	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death	2 Tetopia avana		23d. Date of delive	ery
ם כ	e deat he att ed for	hysician/Me	1 Yes 2 No 4 Pregnant at time of death	3 □ Ectopic pregnancy 5 □ Other <i>(sp</i> ec <i>ify)</i>		Month	Day Year
7. O	at the d by t etach	Phy	9 Li Unknown				
Š,	ires the signe	Š	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the	
Hecords	been should	Completed				2 X No 3 ☐ Prob	abiy 4 Unknown
ě	ne law e has ge 2 s	E I			24a. Was an autopsy performe	prior to coi	psy findings available mpletion of cause of
VITal	in: Th		25. Was case referred to medical		1 □ Yes 2 🕻		2 □ No
>	ysicia s cert	To Be	examiner? 1 ☐ Yes 2 ☒ No	045	th (Check only one)	ce 6 Other (Specific	
סר	g Phy ter thi neral (ü	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how		V)
ğ	endin sath. or: Af he fur	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	!		
DIVISION	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town,	et and Number or Rura State)	l Route Number,
ב	oital c						
	Hosp 24 ho Fune etely f	Medical	29a. Certifier (Check only one) Check only one)	eath occurred at the time, date and place r investigation, in my opinion, death occu	e, and due to the cau urred at the time, date	se(s) and manner as se and place, and due to	tated. the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours aftered. The the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Me	29b. Signature and title of certifier	29c. License number	290	. Date signed (Month,	Day, Year)
	,/		I Chilian ?	D42452	T L	ebruary 8,	2009
	15		30. Name and address of person who compresed cause of death (Item 23a) (Typ		F (Juany 0,	2007
			Chitra Rajagopal, M.D., 18111 Prin	ce Philip Drive, 0	lney, MD 2	20832	
	Sta		31. Date filed (Month, Day, Year) 2009 32. Registrar's Signature	harles			
	Registr	वा	The state of the s	7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

085

10d. Inside City Limits

Approximate Interval Between Onset and Death

Dav

2 □No

29d. Date signed (Month, Day, Year)

Naik

Year

1 ☐ Yes 2 ☐ No

within 24 hours a 10

> State Registrar

Medical

29a, Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRETHER

mp OME

MO OME

32. Registrar's Signature

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an garaje

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1)004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Margaret Mahaney 7, 10:45 p^M 2009 February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Friends Nursing Home Sandy Spring Montgomery 8. Date of Birth (Month, Day, Yea March 12, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Year) 244-40-8374 87 1 □ M 24-34-F 1921 North Carolina Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2X No Director Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20817 7505 Democracy Blvd. USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 ☐ No If Yes, Give Year or Dates: 1943-46 14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🖾 No Specify: Baltimore, Maryland 21215-0036 Specify: þ White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barrett Harriss Katherine Habel ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43904 Loganwood Court, Asburn, VA 20147 19a. Informant's Name/Relationship (Type. Print) Katherine A. Kany/Daughter other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition Department of Important: If it any injury or o 13 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 50 Gate of Heaven Cemetery 2009 Silver Spring, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility ins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY +WZ44LIGEHCA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ENLARGING if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi HSTHMA and ue to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial HUPERTEHSIOH Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ sign be ACCIDENT 1 Yes 2 No 3 Probably 4 Nown YASKULAR Completed INAPPROPRIETE SECRETION OF ANTIDIUXETIC HORMONE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy OSTEOPOROS 13 SIEZURE DISORDEK To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one examiner?
1 Tes 25 No
27. Manner of Death
1 Natural 5 Other: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7109

State

31. Date filed (Month

BRIGGS GAMEY Rd. SILVER SPRING, MA 20905

d address of person who completed cause of death (Item 23a) (Type, Print)

F. GLAHCAITE WD

1731

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** February 2009 12:50 Lou Ellen Michael /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County 12817 The Terrace Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or F Country) 5. Social Security Numbe **Funeral** Days 1 □ M 2 🔀 F June 23,1938 70 236-56-3110 Maryland Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventhan and infined at apprecia 10c. City. Town or Location 10b. County 1 ☐ Yes 2 ☐ XIo Maryland Washington County Hagerstown Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe U.S.A. 21742 12817 The Terrace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 □ No Baltimore, Maryland 21215-0036 Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Credit Card Services Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Yost Morgret John C. Morgret 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17414 Garden View Rd. Hagerstown, MD 21740 Tina Horst-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State Smithsburg Crematory 2-14-2009 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses Kaitlen 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1/2 Immediate Cause (Final disease or condition 41) Physician OVERICA resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 ☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 □ No 1 □ Yes 2 ☑ No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Milarmal

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

McCormack

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ED 17 2000

Some A. Jak

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Medical (amu)

State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar		Ce	ertificate of	Death	Re	eg. No. 2009	00000
		1. Decedent's Name (First, Middle, Las	st)				2. Date of Death		3. Time of Death
Physicia /Medic		Kathleen NMN Mill	.er				February	12 2009	5:45 PM
Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Deat	h	4c. County of Death	1
		18813 Rolling Rd.	•		Hagerst			Washingto	n County
Funeral		Social Security Number 6. S	□M 2□YE	yrs. last birthday	/) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	Year) Cot	nplace (State or Foreign intry)
Director		220-10-3393	92	Yrs.			Feb. 10,	1917 Mar	yland
w w		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or I	ocetion				10d. Inside City Limits
sho	5	,		Hagersto					1 ☐ Yes 2 🛣 No
the N	ect	10e. Street end Number			10f. Zip Code		146	Og. Citizen of What Cou	
a or	喜				2174	2	'`	U.S.A.	and y:
eath	Funeral Director	18813 Rolling Rd.	12. Was Decedent Ever	in U.S. 13	. Was Decedent of H		Specify Yes or No-	14. Race - Amer	ican Indian
fter d	Ē	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 🛣 No		If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	Black, White	
urs a	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 🔀 No	Specify:		Specify: Wh	ite
2 ho	Completed	15. Decedent's Ed	ducation		edent's Usual Occup		etrin a	16b. Kind of Business/li	ndustry
thin 7	ם	(Specify only highest gra	College (1-4or 5+)	life.	e kind of work done DO NOT use retired	d)	-	G1	D.
er th	S	8		Cook	:			Sheriff's	Department
d oth	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, N	*	
Men arke	은	Adam D. Hawbaker				Emma C	. Neff Ha	wbaker	
2 sh and is m raum		19a. Informant's Name/Relationship (Type. Print)					City or Town, State, Z	ip Code)
and lealth im 27 her t	0. 3	Pat Carnes-daught			3 Rolling				
if of h		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Hemovai from State _		oosition (Name of ematory or other place	i		20c. Location - City or T	
t. Pa tmer tant:		4 ☐ Donation 5 ☐ Other (Specify	y) I		en Cemete			Hagerstown	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examination in the Indith of an once.		21. Signature of Funeral Service Licen	see	;			-	Fiery Fune	
		23a. Part 1. Enter the disease, com	Xury	daeth Danaka				lagerstown,	MD 21742 Approximate
		shock, or heart failure. List only	one cause on each line.	death. Do not e	nter the mode of dyli	ng, such as carula	c or respiratory arre	ist,	Interval Between Onset end Death
Physician /Medical	0	Immediate Cause (Final disease or condition resulting in death)	a. IARKINS		DIZEA 35	۷			years
Examiner			Due to (or as a cor	nsequence of):					t.
	Examiner	Sequentially list conditions, if any, leading to immediate	b Due to (or as a cor	nsequence of):					
uted d ansit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
exec an an ial-tra	Exa	resulting in death) Last	Due to (or as a cor	nsequence of):					
leath certificate be executed attending physician and for use as the burial-transit	cal		d						
ntifica ng ph as th	Medical	IE EEN II E							
th ce tendii r use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr	egnancy Fetal death 3	☐ Ectopic pregnanc	ev.		23d. Date of deli	-
ed fo	Physician	in the past 12 months? 1 Yes 2 No	4 Pregnant at time		Other (specify)	···		Month	Day Year
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requi	Completed by	2000	1960 1127				1 □ Ye	s 2 No 3 □ Pro	John Time Time Time Time Time Time Time Time
e law has t	nple						24a. Was ar autopsy	y prior to c	opsy findings available ompletion of cause of
r: The	S						perform 1 □ Yes 2	ned? death? 1 ☐ Yes	2 □ No
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Phys	<u>구</u> :	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient	2 ER/Outpati	ent 3 L DOA	4 LI Nursing F	lome 5 Reside	nce 6 Other (Spec	ify)
ding h. After fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Yea	ar) Injury	Wor	k? K? Yes 2 □ No	28d. Describe no	w injury occurred	
Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home, farm, s			28f. Location (Str	reet and Number or Ru	ral Route Number,
al or after	Certification: To	4 ☐ Homicide determined	building, etc. (S)	pecify)			City or Town	, State)	
psplta hours inera ly fille		29a. Certifier 1X Certifying Ph	nysician: To the best of my	knowledge, dea	ath occurred at the ti	me, date and place	e, and due to the ca	ause(s) and manner as	stated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	one)	niner: On the basis of exa and manner stated.	mination and/or	investigation, in my c	opinion, death occi	arred at the time, da	ate and place, and due	to the cause(s)
To t	Σ	29b. Signature and title of certifier	30.0		29c. Licens	-	29	Od. Date signed (Month	, Day, Year)
		the se	Selver		MD	2794	7	teb 13,	2007
4-7		30. Name and address of person who	completed cause of death 43424 Pen	(Item 23a) (Type	e, Print)	1 202	H = =	own, MD 3	1747
Sta	to	Steven Hatalberg 31. Date filed (Month, Day, Year)	45 T27 En	n5ylvan Signature	ua tive, or	WTC 200	Hagers	own, MU &	1172
Sta Registra		FEB 17 2	1009	1. 1.	book				

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item 1- State Registrar #26, 2/12/09, per f. home, Certificate of Death E.T, WCHD Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 **Physician** AGNES GERTRUDE MITCHELL 10 2009 6:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catered Living at Ocean Pines Ocean Pines Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Ye 6/3/1926 Birthplace (State or Foreign Country) **Funeral** Year) 1 M 2 X F Months Days Hours 82 033-14-5807 **Director** MA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinar must be notified once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐Yes 2 X No MD Worcester Ocean Pines 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21 Camelot Circle 21811 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: white 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Tyler Gertrude Donahue 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn A. Humphrey / daughter 7 Spruce Ct., Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 2/14/2009 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) ral Service Licensee 22. Name and Address of Facility 21. Signature Burbage Funeral Home 108 William St, Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dement's **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Exami and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Difficile within 24 hours after death.

To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 NOther (Specify) Living Assisted Hospital: 1 Yes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Beath 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature ag 29c. License number 29d. Date signed (Month, Day, Year) 2063964 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fraklas And Sile 302 Berlin MO John ET 10 31. Date filed (Month, Day, Year)
FEB 12 2009 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
Theresa Elizabeth Morris 2. Date of Death Day 2009 Month Feb. **Physician** 9, 4:30 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Center Prince George's Clinton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 27, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Wirginia 94 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Show 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it o Medical Examinational to molified at once. Fort Washington 1 □Yes 2 No Maryland Prince George's Director 10g. Citizen of What Country? United States 10f. Zip Code 10e Street and Number 3005 Ramsqate Place 20744 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Quarles Kate Mansfield ဥ 19a. Informant's Name/Relationship (Type. Print)
Samuel J. Morris (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3005 Ramsgate Pl., Ft. Washington, Md. 20744 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Gilliam Old Site
Church Cemetery Date 14, 20a. Method of Disposition 20c. Location - City or Town, State Feb. 1 Burial 2 Cremation 3 Removal from State Louisa, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2009 Thomas sons wat son Funeral Service, Inc. 11/ West St., Louisa, Virginia 23093 21. Signature of Funeral Service Licenses 1261 Approximate Interval Between Onset and Death 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ntia /Medical Dye to (or as a consequence of): Earbolism Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequencé of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed: certificate 1 ☐ Yes 2 ☐ No 1 □ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 2 use of death (Item 23a) (Type, Print) Covingston Roll Fort WASNINGton MA 31. Date filed (Month State Registrar

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Physician /Medical **Examiner**

Funeral Director

28a-f show other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or Pages 1 and 2 should be filed within 72 hours after than marked other ith and Mental H

Saltimore, Maryland 21215-0036

Physician /Medical Examiner

Department of Health an Important: If item 27 Is any Injury or other trau

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 P.O. Division of Vital Records, has After in 24 hours after death.

Re Funeral Director: A pletely filled in by the filled.

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year MODRE SWAL M: 23 M 2009 FERCLIARY 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 2√X Months Days Hours 213 18 9525 90 Nov 12. 1918 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's 1 □Yes XX No Director Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7501 S. Osborne Road 20772 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 ☐ No Specify \$ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Winter Gibson Mable Jackson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luther A. Moore (husband) 7501 S. Osborne Road, Upper Maryland Feb 19, 2009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Murial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Ligensee Distrant Alexandria Ferry Road, Clinton, MD Fair 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final HICANIC disease or condition resulting in death) Due to (or as a consequence of) NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) DNGESTIVE Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖎 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 32. Registrar's Signature 31. Date filed (Month. State Registrar

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** ,2009 February 6 Viola Wood McDonald /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 2574 S. Haven Road Annapolis, Maryland Anne Arundel LaCasa, If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🗓 F 1922 Maryland Director 579-18-5004 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Modical Examinat must be profitted at 1 □Yes 2 □ No Temple Hills, Maryland Maryland Prince George Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number States 20722 United 4801 Branch Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2√ No If Yes, Given X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ No Specify Specify: White Baltimore, Maryland 21215-0036 3 ₩idowed 4 □ Divorced Completed by 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Linda V. Soper P Thomas E. Wood Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8633 Dangerfield Place Clinton, MD 207

Date 20c. Location - City or Town, State MD 20735 Rose Long (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Barnabas Church Feb 12,2009 Temple Hiils, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee Alexandria Ferry Road, Clinton, MD 20735 Gi_ Fart 1. Enter the disease, or complications like t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician an s the burial-tr Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23d. Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 1/2 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 Nde 2 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Definer (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Deatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

29b. Signature an title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 1 1 2009

32. Redistrar's Signature

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

17

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29d. Date signed (Month, Day, Year)

COSTAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 **Physician** MUNDY Feb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Oak Talbot Royal 5800 Dawson Street Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 4-32-1036 July 23.1932 Maryland Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experiment has notified at 1 Nes 2 No Funeral Director albot 10g. Citizen of What Country? 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyres 2 No 1953 If Yes, Give Year or Dates: 1954 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Health and Mental Hygiene. em 27 is marked other than "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturina perator 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Ardella Ρο 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) St. P.O.BOX 13-ROYAL DAK, MP. 21662 permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau illie Mae 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Veterans Cemetery HUYlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HENRY FUNERAL Home, P.A. 510 Washington St. Cambridge MD. 21613 23a. Petr. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erebrovascu accident)eek Physician /Medical Due to (or as a consequence of): Examiner cardiom hemic Esquernany flot conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hypertension burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No 24a. Was an autopsy performed? 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27, Manner of Death 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

be executed and attending physician for use as the burial Box 68760 Hospital or Attending Physician: The law requires that the death certificate signed by the a d be detached for P.0. Division of Vital Records, certificate has been si rector, page 2 should I this within 24 hours after death.

To the Funeral Director: After

72 hours after

Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

FEBRUARY

2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

219 South Washington Street, Easton, MD Lakshmi Vaidyanathan, B1. Date filed (Month, Day, Year) M.D., 31. Date filed (Month, Day, Year)

State Registrar

completely

Medical

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 11:30 A_M FEBRUARY 10 2009 JOHN RUSSELL MCCONNELL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAPOLIS If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1 XM 2 ☐ F OCTOBER 21, 1929 PENNSYLVANIA 168-24-1030 79 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 27 is marked other than "natural", or Items 23a or 28a-f show treumatic event, the Medical Examinar must be notified at 1 FYes 2 □ No ANNAPOLIS Director **MARYLAND** ANNE ARUNDEL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1616 SLOOP DRIVE 21409 UNITED STATES death by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. snt: If item 27 is markad other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **EDUCATION EDUCATOR** 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be H. DOROTHY BECHTEL J.R. MCCONNELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1616 SLOOP DRIVE, ANNAPOLIS, MARYLAND 21409 LOIS MCCONNELL/WIFE other 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition WENTZ" UNITED" CHURCH FEBRUARY 13 I 🕱 Burial 2 □ Cremation 3 □ Removal from State ō permit. Page Department of importent: If any injury or once. WORCESTER, PENNSYLVANIA 4 ☐ Donation 5 ☐ Other (Specify) OF CHRIST CEMETERY 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause vaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The taw requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physiclan for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Yea in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: **Director:** After this certific I in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Inpatient 25 No 10 1 Tes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours e To the Funerei I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Med 29d. Date signed (Month, Day, Year) certifier 29c. License number 29b. Signatu ddress of person who completed cause of death (Item 23a) (Type, Print) Medical MARKWA 2001 31. Date filed (Mo 2. Registrar's Signature State Registrar

09-01419	
Myrtle Moore	

rtle Moore		For State	ate of Maryla	and / Dep <i>Ce</i>	artment of ertificate of	Health <i>Death</i>	and N	Mental I		eg. No. 20(9 0605
Physician	1	Decedent's Name (First, Midd							2. Date of Dea Month	Day Year	3. Time of Death 0330 hrs
edical Examin		Myrtle Mo	on, give street and nu	ımber)		4b. City, Tov	n, or Loc	ation of Dea	February	4c. County of Dea	
		Anne Arundel Medica	-			Annapo	lis			Anne Arund	
Funeral Director		5. Social Security Number 421 – 42 – 9875	6. Sex	7. Age (In yrs	. last birthday) 6 Yrs	If Under. Months	_	Hours N		For	Birthplace (State or eign CountryAlabama
as all regions and the	_	Jsual Residence of Decedent									10d. Inside City Limits
w any	1	MD Anne	Arundel	10c. Cit	ty, Town or Locat		bril.	ls			1 Yes 2 No
ryland a-f sho t once	흕	10e. Street and Number	Arthuci			10f. Zip C			1	0g. Citizen of What C	ountry?
ith the Maryland 23a or 28a-f show any notified at once.	Director	1515 Defense I	Highway			21	054			US	SA
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once		11. Marital Status 1 Never Married 2 N		cedent Ever in forces?	If Y				Specify Yes or No rto Rican, etc.)	14. Race - Am White, etc	erican Indian, Black, .
after de	고	3 Widowed 4 X Di	vorced If Yes, Give Ye or Dates:	-	1	Yes 2 ^X				Specify: Wi	
5-0036 led within 72 hours afte tygiene other than "natural",		15. Decedent's Education (Spe Elementary/Secondary (0-12		de completed) 1-4 or 5+)	16a. Deceder during m	nt's Usual O nost of worki	ccupation ng life. Do	(Give kind O NOT use	of work done retired)	16b. Kind of Busines	ss/industry
5-0036 ed within 72 tygiene other than " the Medical J	Completed	12	College (1-40101)	Ţ [ailor				Retail (Clothing
		17. Father's Name (First, Middle			E. Roi	11 11				Maiden Surname)	1_
2121 uld'be fil Mental F marked c event,	To Be	Carlin Car. 19a. Informant's Name/Relation		liard	19b. Mailin	g Address		Lina nd Number	Beatric or Rural Route Nu	ce Edward mber, City or Town, St	
ore, MD 2 ges I and 2 shou of Health and N I If iten 27 is n ther tranmatic		James Allen M		ce/Son	117	CCC R			nden, Vii	rginia 2264	12
re, F s I and f Healt If iten		20a. Method of Disposition 1 Burial 2 Crematic	n 3 Removal f		 b. Place of Disport crematory or of 		of ceme	1	Date	20c. Location - City	
Pag m en l	1	4 Donation 5 Other S	Specify:	В	ayview C				21/2009		, Maryland
Baltimo permit Pag Department Important: injury or of		21. Signature of Funeral Service	e Licensee	7		Name and A				neral Home owie, MD 20	715
Physician	+	23a. Part I. Enter the disease, of	or complice ons that	caused the dea							Approximate Interval
Medical xaminer	1	failure. List only one cause Immediate Cause (Final diseas	e a comp1		ns of br	ain tu	mor				Death
	-	or condition resulting in death)	Due to (or as	a consequence	e of):						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus		a consequenc	e of): ,		-2		U	11111	
_ = =	Examiner	(Disease or injury that initiated events resulting in death) Last	Frankskin in	a consequenc	e of).						- 1
and and		X UNPENDED	d	23a,P]	11,27,28	a-f,p	rME,	G890	4/14/09	TT	
50, te be ex nysician	Nedical	IF FEMALE:		, outcome of p			_			23d. Date of deli	very
Box 6876C The death certificate to the attending physe hed for use as the beath of	sician/M	23b. Was decedent pregnant in past 12 months?	the 1 Live	birth gnant at time of	2 F	etal death	3	Ectopic pre	egnancy	Month	Day Year
30x death o	ysic	1 Yes 2 V No 9 U	nknoum	nown	5 C	other (Spec	(y)				
Division of Vital Records, P.O. Box 6876 the Hospital or Atending Physician: The law requires that the death certificate hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phy updetely filled in by the funeral director, page 2 should be detached for use as the benefits the content of the content	by Phy	Part II. Other significant cond		to death but n	ot resulting in the	underlying	cause giv	en in Part I.			e to the cause of death? Probably 4 Unknown
ords, F		Neck inju	iries						24a. Wa		autopsy findings available to completion of cause of
e law r e has b	Completed	ļ 		<u> </u>						formed? deat	
tal Re(cian: The certificate ector, page	O I	25. Was case referred to media	cal			2			eck only one)		-
n of Vital Rec fing Physician: The I After this certificate I funeral director, page	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1		✓ ER/Outpatie				ursing Home 5	Residence 6 C	ther:
n of ding P h. After		27. Manner of Death 1 Natural 5 Pe	(Mor	te of Injury nth, Day,Year)	28b. Time of			at Work? s 2 X No		e now injury occurred	
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should be	Certification:	2 Accident In	restination FQ		At home, farm, str		office bu	lding, etc.	28f. Location	(Street and Number of State) 1515 De	r Rural Route Number, City fense Hwy
Div pital o ours af teral D	Certi	4 Homicide de	termined (Specif						Gambr1	IIs, MD	
he Hos in 24 h he Fun pletely		29a. Certifier (Check only one) Certifying	Physician: To the b kaminer:On the basi	est of my know is of examination	vledge, death occ on and/or investig	urred at the ation, in my	time, date opinion,	e and place, death occur	and due to the ca red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
To the within To the comple	Medical	29b. Signature and title of cert	and manne	r stated.			License			29d. Date signed	
O Co		Someth 9 VII	wthall in	A			O.C.N	I.E.		February 19,	2009
8/		30. Name and ddress of pers				44 Dami	Ctrt	Daltimas	o MD 21201		
J		Pamela E. Southall,				11 Penn	Street,	Baltimor	e, MD 21201		
St	ate	FFB 2 3 2009 Yes	1) Phases 32.	Regultrar's S	Cillan						

State of Marvland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Vear **Physician** 2009 7:44 a.m. 18. Miles Lind Moore February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary' 46125 East Sunrise Drive S Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 1 ☐ M 2 🛣 F Yrs 82 06/24/1926 Washington, DC Director 577-30-1773 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be recitlied at 1 ☐ Yes 2 X No Director Washington, DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 20015 3050 Military Road, NW <u>United States</u> Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) nit. Pages 1 and 2 should be filed within 72 hours after or artment of Health and Mental Hygiene. ortant: If item 27 Is marked other than "natural", or iten Injury or other traumatic event, the Medical Examina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛛 No Specify: þ 3 Widowed 4 NDivorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Miles Street ပ John Eugene Lind 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Kathryn Franzen/Daughter</u> 46125 East Sunrise Drive, Lexington Park, MD 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 02/19/2009 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass or injury) Due to (or as a consequence of): Examiner ospital or Attending Physician: The law requires that the death certificate be executed hours after death.

Juneral Director: After this certificate has been signed by the attending physician and infinite by the furnerial director, page 2 should be detached for use as the burfal-transit infinite in by the furnerial director, page 2 should be detached for use as the burfal-transit. Cause (Discass or inju-that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 NOther (Specify Residence Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 140055751 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . 40900 Merchants Lane, Leonardtown, MD Jennifer Schmidt, D.O. 31. Date filed (A State 2009 of problems Registrar

State of Maryland / Department of Health and Mental Hygiene 0 6 U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death **Physician** 10:15 am February 06 2009 Vernice E. Netteburg /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 10887 Lockwood Drive Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🛛 F Yrs Director 92 September 12,1916 Minnesota 477-38-2351 Usual Residence of Decedent fshow 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, II o Madical Examiner must be notified at 1 ☐ Yes 2 🖾 No Director Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10887 Lockwood 20901 U.S.A. Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy important; if Item 27 is marked other any injury or other traumatic ances. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Hedeen Carl Peterson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kermit Netteburg - Son 10887 Lockwood Drive, Silver Spring, Maryland 20901 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 02/13/2009 4 Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory Brentwood, Maryland Functed Surve 21. Signature 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Jules Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Cardiac Arrhythmia 1 year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) cords, P.O. Box 68760, cequires that the death certificate be executed sician and burial-tran resulting in death) Last Due to (or as a consequence of): anding physician ause as the burial-Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant the atten 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 🖾 No 9 ☐ Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law cate has I page 2 s autopsy performed? certificate 1 ☐Yes 2 ☒ No 2 No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending Factor death.

I Director, After din by the funera 1 🛭 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3 3 009 2/9/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Barth, M.D., 11161 New Hampshire Avenue, Suite 201, Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 72:30PM February 500 0 /Medical 4a. Facility Name (If not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1**X** M 2 □ F Yrs. 132-30-1704 68 Dec 7, **Director** 1940 Tennessee Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 9002 Ivanhoe Road 20744 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

↑★□ Yes 2 □ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian African American 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify þ Specify 3 Widowed 4 Divorced "natural" Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Director Government 4 vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Tyree Smith Dorothy Wiggins ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trainonce. Hilda Geddings-Oshon / Wife 9002 Ivanhoe Road Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lee's Crematory Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Feb 13, 2009 Clinton, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatio MUTCICL disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Certification: To Director: After this d in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

State

Mahannan Sanna 32. Registrar's Signature 31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

29c. License number

Q

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06061 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 18, 2009 February 0635 Charles Thomas Odom 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Towson Baltimore Gilcrest Center for Hospice Care NC Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/9/1924 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Hours 1⊠ M 2□ F 228-20-8652 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Y Yes 2 □ No Baltimore 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21234 8820 Walthers Blvd. Apt. 3403 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰yes 2 □ No If Yes, Give Year or Dates:WWII 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 ∐ Yes 2, ZNNo Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chief of Artillery U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Linwood Odom Mary Bennett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8820 Walthers Blvd. Apt. 3403 Baltimore, MD 21234 Doris Odom (Spouse) 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State 2/23/09 Baker Cemetery Aberdeen, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. 21. Signature of Funeral Service Licensee Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

Department of Health a Important: If item 27 is any injury or other tran once.

1 - For State Registrar

10a. State

MD

Director

Funeral

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Completed

Be

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5. Social Security Number

10e. Street and Number

Physician

/Medical

Examiner

Funeral

Director

and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experient institute to notified at

physician and s the burial-trans

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	blications that caused the death. Do not enter the mode of dying, such as cardiac one cause on each line.	or respiratory arrest,	Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a. Diatence Nepworethy Due to (or as a consequence of):		year
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):		
cal Exan	that initiated events resulting in death) Last	C		
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of de Month	elivery Day Year
d by Ph	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	to the cause of death? Probably 4 ☐ Unknowr
complete	06 showing	Pulmorrary discase	autopsy prior to performed? peath?	utopsy findings available completion of cause of s 2 \(\subsection \) No
0	25. Was case referred to medical	26. Place of Dea	th (Check only one)	
o Be	examiner? 1 ☐ Yes 2 No		lome 5 ☐ Residence 6 ☐ Other (Sp	ecify) hospiq
ation: 1	27. Manner of Death Natural 5 Pending Description investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred	
Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or F City or Town, State)	Rural Route Number,
ical	29a. Certifier (Check only 2 Medical Exam	nysician: To the best of my knowledge, death occurred at the time, date and place niner: On the basis of examination and/or investigation, in my opinion, death occurred and manager stated.	e, and due to the cause(s) and manner are at the time, date and place, and du	as stated. ue to the cause(s)

29c. License number

D64395

29d. Date signed (Month, Day, Year)

FEBRUARY 18, 2009

State Registrar 29b. Signature and title of certifier

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

6565 NCHARUSSTI SUITE 209 BALTIMORE, MO 21204 DANIEUE DOBERMAN, MO

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

			For State Registrar		State of Ma	aryiand	•	irtment of r tificate of	neaith and i Death		eg. No.2	09	06062	
			Decedent's Name ((First, Middle, Las	t)				**	Date of Deat Month		Year	3. Time of Death	
	Physici /Medic		Julie Kol	lker Pols	sky					02/09/2		real	6:10 p M	
The state of the s	Examin		4a. Facility Name (If n						r Location of Death		4c. Cou	nty of Death	-	
4			Suburban 5. Social Security Nun			o (In ure la	ast birthday)	Be 1	thesda If Under 24 Hrs.	8. Date of Birth	1	Montg	omery place (State or Foreign	
L	Funeral Director		578-64-294 Usual Residence of D	17	M 2⊠F	50	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 04/21/1	Year) 958	Coui	ington, DC	
1.	/land			10b. County		10c. City,	, Town or Lo	cation				1	0d. Inside City Limits	
TR	Many a-f sh ifed	tor	Maryland	Montgome	ery	Rock	cville						1.25Yes 2. □No	
1	or 28a)ire	10e. Street and Numb		-			10f. Zip Code	·	1	0g. Citizen	of What Cour	ntry?	
	death with	ral	5812 Magic	Mountai	in Drive			20852			USA			
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death witt ∑he Marylan it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 2a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4		12. Was Decedent! Armed Forces? 1 □ Yes 2 ▼ ! If Yes, Give Year or Dates:			Was Decedent of H fYes, specify Cub I□Yes 2√∑No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	E	Race - Americ Black, White, cify: Wh		
5-0	72 ho	eted		5. Decedent's Ed		Į	16a. Deced	lent's Usual Occup	oation during most of work	ina i	16b. Kind of	Business/In	dustry	
121	ithin ne.	mpl	Elementary/Second		College (1-4or 5	i+)	-		during most of work d)	9	D/1	_		
2	iled w Hygie ther t	ပ္ပ	17. Father's Name (Fi	irst. Middle. Last)	4		Instr	uctor	18. Mother's Name	e (First, Middle, I	Pilat Maiden Surn			
au	d be tental	To Be	Irvin Kolk						Hannah Ro	- (, , , ,				
ary	shoul and M s mar umat	۲	19a. Informant's Nam	ne/Relationship (7			19b. Mailir	g Address (Street	and Number or Rui				Code)	
Ž,	and 2 saith a 1 27 is		James Pols	sky, hust	and		5812	Magic Mo	ountain D	rive, Ro	ckvil:	le, MD	20852	
ore	ges 1 and of the life of the l			Cremation 3	Removal from State		ace of Dispo emetery, cren	sition (Name of natory or other plac	ce)	Date	20c. Locatio	on - City or To	own, State	
Baltimore,	t. Pa rtmer rtant njury		4 ☐ Donation 5			Jud	22	. Name and Addre	Gdns 02/11			, Mary	Land	
ä	permi Depai Impoi any Ir	9	R CAPA	d			E	OWARD SAC 091 Rocks	GEL FÚNERA Ville Pika	AL DIREC Rocky	TION, ille,	INC. Maryl		
				failure. List only	plications that caused one cause on each li	or respiratory arr	est,		Approximate Interval Between Onset and Death					
-	Physician /Medical		Immediate Cause (Fi disease or condition resulting in death)	disease or condition Respiratory Arrest										
3	Examiner					2 weeks								
Δ	P #	ner	Sequentially list cond cause. Enter Underly Cause (Disease or in that initiated events	litions, ediate	5ue to (or as			ng Cancer	-				Z WEEKS	
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.0. Box	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent p in the past 12 m 1 □ Yes 2 □ 9 □ Unknown	onths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3 [Ectopic pregnance Other (specify)	су			Date of deliv Month	ery Day Year	
S, P.	es that igned b		Part II. Other signification		_	ut not resul	lting in the ur	nderlying cause giv	en in Part I.				he cause of death?	
ord	requir een s	ted	Hodgkin's	Бушриоша	<u> </u>					1 □ Ye			bably 4 Unknown	
Rec	The law ate has b	Completed by								24a. Was a autops perform	n 24 by ned? 2 🙀 No	b. Were auto prior to co death? 1 \(\sum Yes	opsy findings available impletion of cause of	
Vital	Physician: rthis certific ral director, I	Be	25. Was case referred examiner? 1 ☐ Yes 2 ☑ No.	Í	Hospital:		ER/Outpatier	. action Oth	26. Place of Deat				<u> </u>	
of	g Phy er this eral d	n: To	27. Manner of Death		28a. Date of Inju (Month, Da		28b. Time of	28c. Inju	ry at	ome 5 Reside			<u>fy)</u>	
ion	Attending r death. sctor: After by the funer	atio	1 🔀Natural 2 ☐ Accident	5 Pending investigation		y, Year)	Injury	M 1 □	'k?]Yes 2 □No					
Division of	al or Atte s after de al Directo ed in by th	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injubulding, etc.	ury - At hor c. (Specify	me, farm, str	eet, factory, office		28f. Location (St City or Town		mber or Rura	al Route Number,	
	the Hospital or hin 24 hours afte the Funeral Din mpletely filled in I	Medical (ysician: To the best niner: On the basis o and manner sta	f examinati								
	within comp	ž	29b. Signature and tit	de of certifier				29c. Licens		2	1 i	ned (Month,	Day, Year)	
	15			1/1	WD				66990	2	2/10/0	4		
			30. Name and address			leath (Item	23a) (Type,	Print)	4100, Bet	lusda M	n .20	2817		
	Sta	te	31. Date filed (Month)	101	32 Registr	ar's Signati	ure /	-	1100 1901		2 00	01/		
	Registr		FE	B 11 20	109 ann	NA	7. 190	Mad						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are L State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No: Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Whasoon Hong Park 9:30 February 07 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖾 F Min Director 469-72-6862 86 April 25, 1922 Korea Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examinat must be notified at 1 ☐ Yes 2 K No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1641-A Carriagehouse Terrace 20904 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 Ñ No Specify. þ Specify. 3 ☑ Widowed 4 ☐ Divorced "natural" Asian Be Completed d other than "natu 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Health and Mental Hygiene. em 27 is marked other thar ther traumatic event, in a College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Ho Hong Shin Young Kim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other t John J. Park - Son 31 Riggs Road, Fredericksburg, Virginia 22405 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I Important: If its any Injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) Norbeck Memorial Park 02/11/2009 Olney, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Adult Failure to Thrive disease or condition resulting in death) Months /Medical Due to (or as a consequence of): **Examiner** Type 2 Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Years Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and burial-transit Diabetic Gastroparesis Months Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Labile Hypertension Years the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Year Day signed by the a d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>م</u> icate has been siç , page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 2 40 1 ☐ Yes 2 ☐ No. 1 □ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 15 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00065485 panich RSM NO

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06064 State of Maryland / Department of Health and Mental Hygiene 000 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 06 **Physician** 2009 Linda Diane Purdum-King 5:15 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll 2416 Kays Mill Road Finksburg 8. Date of Birth (Month, Day, May 27 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Min. 1951 Months Hours 1 □ M 2 1 F 57 Director 217-62-0978 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Finksburg MD Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21048 USA 2416 Kays Mill Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 31 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nursing Homes Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental h Betty Kelly ဥ Milton Dean Lanier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is Studio 6 Brooklyn, NY 11211 Ashley Purdum/daughter 242 White Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Removal from State Carroll Cremation, Inc 2/09/2009 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie Printed TimestallivHome and Chapel, P.A. 21157 412 Washington Road Westminster, MD Inter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 2 -NO 2 PNo 1□ Yes 1 TYes To the Hospital or Attending Physician: the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient ၉ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check o one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu and title of certifier WJL 10 completed cause of death (Item 23a) (Type, Print)

D 555 South CoutoR Street (Wostminston, 11021157 Plavio hruter mo 555

State

Registrar

FEB 1 0 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 03 2009 3:00 PM 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner town ester If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 1 Year Social Security Number **Funeral** Days Months Hours 1 MM 2 F 0618 2/5-36-06/8 Usual Residence of Decedent 6 Director 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ortant; If Item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Nortor Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2167 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. popular rages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Hem 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evanimon 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. 20c. Location - City or Town, State Newtow Place of Disposition (Name of cemetery, crematory or other place) 20b. Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State Worton, 5 Other (Specify) 21. Signature of Funeral Service License BennieSmithFH Worton, MD 21678 Koute 298 Approximate Interval Between Onset and Death Enter the dise set, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequate of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly 19 Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 No signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 ☐ Unknown Completed 8 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an s certificate has b lirector, page 2 sl 1 25. Was case referre medical examiner?

1 Yes 2 No Be 26. Place of Death Check onl one Hospital: Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manne of Death 28c. Injury at Work? After I Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check onlone) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of D0036054 09

State Registrar cause of death (Item 23a) (Type, Print) IAN MD 120 Speer Rd Bldg B Chestertown MD 21620

Robert Pearson 219-62-8964

altimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Wayne Pearson **Physician** Robert 6412 M 2009 FEL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Namico SAUSBURY REGIONAL MEDKAL TENINSUM If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 05/09/1953 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 □ F 219-62-8964 Virginia 55 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Salisbury Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ö 21804 USA 406 Pacific Ave. 23a Funeral items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 X No 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Modical Examiner once. Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2X No Specify: white 3 Widowed 4 K Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) mechanic automotive 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beulah Morley Norman Pearson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6992 Amber Fields Ct., Salisbury, MD 21804 19a. Informant's Name/Relationship (Type. Print) Angel Booth/daughter Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State 2/9/09 Salisbury Crematory Salisbury, MD 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Li-240110Way Funeral Home Professional Association Kell 501 Snow Hill Rd., Salisbury, MD 21804 LUBE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. lardiac arrest to Cangestine Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or es a consequence of): Examiner Pulmanam Saventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit COPY And Rheumaraid Lung 10 4500 Due to (or as a consequence of): Physician/Medical 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Rheumataid Arthritis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Mile 126612 2.6.09

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State Registrar

FEB 1 2 2009 31. Date filed (Month

٦,

Michael

Crouch 32. R gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Charl & Crouch MD, 105 P, 2 B, 24 S, 7, SAISbury, MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene? 1 1 9

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			For State C	f Maryland / L		rtment of F tificate of I			gienę Reg. No.	000	00001
	Physicia	1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medical Examiner William Roger Peddicord 4a. Facility Name (If not institution, give street and number)					4b. City, Town, or	Location of Death	FEBRU <i>E</i>		3 2009 county of Death	4:00P "
~ .	Examili	CI	Berlin Nursing Home	Berlin				orcester			
	Funeral Director		5. Social Security Number 217-16-3055 6. Sex 1 M 2 □ F	7. Age (In yrs. last birt	hday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt 1/31/1	924 ⁾	9. Birthi Coul	place (State or Foreign ntry) MD
Baltimore, Maryland 21215-0036	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Lo	cation				1	0d. Inside City Limits
	e Mary ia-f sh	ctor	MD Worcester	Berl	in						1 ☐ Yes 2 🛣 No
	with the	Director	10e. Street and Number 11647 Beauchamp Rd.			10f. Zip Code 21811			-	en of What Cour JSA	ntry?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Marical Evanting 4.	Funeral	11. Marital Status 12. Was Dec		13. V		ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		4. Race - Americ Black, White,	
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ylan	Mental Mental arked o		William Peddicord				Ruth Whi				
timore, Mary	nd 2 sho Ith and 27 is m r traum		19a. Informant's Name/Relationship (Type. Print) James R. Peddicord / sor			•	and Number or Rura ew Dr., B				Code)
	of Hea		20a. Method of Disposition	20b. Place of		sition (Name of natory or other place		ate		ation - City or To	own, State
	t. Pag rtment rtant: It		1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Cape H		open Crei		/2009		nkford,	DE
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	Physician /Medical			aused the death. Do neach line.	ΠC		_			SE.	Approximate Interval Between Onset and Death
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	Physla rthis c ral dire	은	1 Yes 2 No Hospital: 1 □	Inpatient 2 ER/Ou	<u> </u>		4 LLZ Nursing Ho				(y)
ion	ending sath. or: After he fune	ation	1 ☑Natural 5 □ Pending (Month, Day, Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No								
Divis	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ledical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place build	of Injury - At home, faring, etc. (Specify)	rm, stre	eet, factory, office		28f. Location (5 City or Tov	Street and vn, State)	Number or Rura	al Route Number,
	e Hospit 124 hour e Funera letely fille		29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To the vithing to the composite of the c	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
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E	SASTI		30. Name and address of person who completed cau	θ of death (Item 23a) (Type,	EASTA	-KN SH	ME D	n, Si	ALISBU	EY MD21804
	Sta		31. Date filed (Month, Day, Year) 32. F	Segistrar's Signature					1 -	, , , , , , , , , , , , , , , , , , , ,	

DHMH 17 Rev 1/2001

State

Registrar

FEB 1 2 2009

PEDDICORD, WILLIAM

parke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death

Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 7:31 am Februar 2000 JOHNNIE LANE PARKER, SR. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Plata Civista Medical Conter 6 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**√** M 2□ F Months Days DECEMBER 28, 1952 WASHINGTON.D.C. 577-74-2333 56 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 No MARYLAND CHARLES WALDORF 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4703A ROOKWOOD PLACE 20602 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: BLACK 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 2 YEARS (1-4or 5+) INDEPENDENT CONTRACTOR CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HATTIE LOUISE WEBSTER PARKER JOHNNIE PARKER. JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JOHNNIE L. PARKER, JR./ SON 12459 SAN JOSE LANE, LUSBY, MARYLAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State WILDY FAMILY CEMETERY FEB. 16, 2009 HEATHSVILLE, VIRGINIA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses THURNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNION JOHNSON MOO583 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Isa hamic Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐*Yes 2 ☐ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier

Physician /Medical Examiner Division of Vital Records, P.O. Box 68760,

b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
P. Thours after death.
P. There is a Funeral Director: After this certificate has been signed by the attending physician and burial filled in by within 24 hor To the Fune completely fi

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Funeral Director

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Completed

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Physician/Medical

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Certification: To

Medical

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shou important: If item 27 is marked other than "natural", or items 25 or 28a-f should alway Injury or other traumatic event, Ira Medical Evaminer must be notified at once.

Pages 1

State Registrar

31. Date filed (Month, Day, Year) FFR 1 1 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) auri NID 32. Registrar's Signature

1/655 wine 5-p pl

29c. License number

29d. Date signed (Month, Day, Year)

2/9/2009

29b. Signature and title of certifier

elvier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 06069 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Mary Janet Purdy Feb 21, 2009 5:10 p^M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Allegany** Moran Manor Westernport 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 1 ☐ M 2 🔀 F Months Days Hours 232**-**54**-**4267 12/30/14 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Allegany McCoole 1x Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21562 21416 Chesapeake Ave. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Management Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Black Smith Lenora Agnes Schade 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Purdy/son 23909 McMullen Hgwy, SW, Rawlings, MD 21557 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State MBurial 2 ☐ Cremation 3 ☐ Removal from State Potomac Memorial: 2/24/09 4 ☐ Donation 5 ☐ Other (Specify) Keyser, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harkwood Funeral Home, In P.O. Box 912, Keyser, WV

23a. Part1. Enter the disease, or complications that cansed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Inc. IV 26726 Approximate Interval Between Onset and Death Immediate Cause (Final 5 sopha Cancer disease or condition resulting in death) Due to (or as a c sequenc of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Mnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner.

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division or Vital Records,

To the Hospital or Attending

certificate be

/Medical

MD

Director

Funeral

Completed by

Be

Examine burial-tran attending physician Physician/Medical as the for signed by the at d be detached for þ Completed page 2 s certificate Be this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

25. Was case referred to medical examiner?

6 ☐ Could not be

determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation

and manner stated.

28b. Time of Injury

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other:

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

autopsy

24 No

1∐ Yes

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 Yes 2 No

27. Manner of Death

1 1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

D21244

2/23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 21532 4 Broadway St., Frostburg, Jesus H. Tan, MD

State Registrar

Medical

FEB 2 6 2009

32. Redistrar's Signature

DHMH 17 Rev 1/2001

DIL

09-01456 Tricia Quillen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 06070

		1- For State Certificate of Death Registrar		. No.	0001			
Physicia	n/	1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death			
Medical Examin		TRICIA JILL QUILLEN	Month February 18		1907 hrs			
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Hospital Baltimore		4c. County of Deat	h			
			To Date of Diet	in in the second of the				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min		(MM/DD/YYYY) 9. Bi Forei	gn			
Director		216-80-4001 1 M 2XF 34 Yrs. World's Bays 110013	11/3/1	1974 C	ountry) MD			
8	-	Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County			10d. Inside City Limits			
w any								
Aaryland 28a-f show 1 at once.	ខ្ម	MD QUEEN ANNE'S MILLINGTON			1 Yes 2 X No			
Mary Mary	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cou	untry?			
ith the Maryland 23a or 28a-f sho		117 CLEAR SPRING PLACE 21651		USA				
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Signature of Marrian Status) 14. Was Decedent Ever in U.S. 15. Was Decedent of Hispanic Origin? (Signature of Hispanic Origin?)		14. Race - Ame White, etc.	rican Indian, Black,			
or ite	틧	1 Yes 2 X No	rticari, etc./					
after	6	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specify:		op comy.	ITE			
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timent traint:			24/09	CRUMPTON,	MD			
Baltimore, permit Pages I at Department of Her Important: If ite Important: If ite Imjury or other tr		21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBE	IN & NEWN	NAM FUNERA	L HOME			
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Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director: Completely filled in by the	io I	one) 2 • Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred						
To vit.	ᆰ	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (M	onth, Day, Year)			
		O.C.M.E.	February 19, 2					
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}		30. Name and adoptess of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201					
Sta	fe							
Registra		31. Date filed (Month, Day, Year) 32. Registra's Signature FER 2 0 2009						

DHMH 17 Rev 1/2001 OCME 2006

		For State Registrar	State of Maryland / D	epartment of Healtl Certificate of Deat		piene eg. No 2009 06071			
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Physici /Medi		Marianne	Ross		Month 02	Day Year 17:36PM			
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Funeral Director		5. Social Security Number 6. S 219–56–8039	Du oMr	hday) If Under 1 Year If Under 1 Year Months Days Hour	der 24 Hrs. 8. Date of Birth (Month, Day) 03-12-1				
pu		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits			
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the N	ect	MD Somers 10e. Street and Number	et Princ	ess Anne	11	0g. Citizen of What Country?			
3a or		11867 Crisfield	Lane	21853		USA			
death ms 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specify Yes or No-	14. Race - American Indian,			
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21215-0036 d within 72 hours after death with the Maryland giene. er than "natural", or Items 23a or 28a-f show the Medical Evantine must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		Decedent's Usual Occupation (Give kind of work done during rr life, DO NOT use retired)	nost of working	16b. Kind of Business/Industry			
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Maryland 212. d 2 should be filed within th and Mental Hygiene. 77 is marked other tan traumatic event, from		19a. Informant's Name/Relationship (Type. Print) 19b.		-	r, City or Town, State, Zip Code)			
≥ 5 € 2 €		Rick White/broth			Ct., Pocomoke	City, MD 21851			
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<u> </u>		men yuu	New M00295 plications that caused the death. Do n	11673 Somerset	Ave., Prince	est, MD 21853			
Physician /Medical Examiner		shock, or heart failure. List only mediate Cause (Final disease or condition resulting in death)	a. Pare cattle Due to (or as a consequence of	S. Poilere		Interval Between Onset and Death			
I Records, P.O. Box 68760, The law requires that the death certificate be executed are has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Sequentially list conditions. Sequentially list conditions for any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								
c 68 ertifica ing pl	Med	IF FEMALE:			-				
P.O. Box 6 at the death certific by the attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		23d. Date of delivery Month Day Year				
Records, P. he law requires that the has been signed by tge 2 should be detact	2	Part II. Other significant conditions of	contributing to death but not resulting in	the underlying cause given in Pa	rt I. 23e. Did tol	pacco use contribute to the cause of death? es 2 ☐ No 3 ☐ Probably 4 ☐ Unknown			
cord w requir s been s s bould	lete				24a. Was a	n 24b. Were autopsy findings available			
The lar	Completed				autops perforr	ned? death?			
of Vital F Physician: The rthis certificate ral director, pag	O I	25. Was case referred to medical		26. Pla	1 ☐ Yes 2 ace of Death (Check only on	2 ☐NO 1 ☐ Yes 2 ☐ No			
of Vita Physician: this certific	P B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	Othor	Nursing Home 5 ☐ Reside				
on of	ü	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day, Year) 28b. T	ime of 28c. Injury at jury Work?	28d. Describe ho	28d. Describe how injury occurred			
/isi Atten r deatl ector: by the	Certification:	2 Accident investigation 3 Suicide GCould not b 4 Homicide determined	1	M 1 □Yes 2	28f. Location (St	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
urs urs gral		(Check only 2 Medical Exar	nysician: To the best of my knowledge miner: On the basis of examination and	death occurred at the time, date	e and place, and due to the c death occurred at the time, d	ause(s) and manner as stated. ate and place, and due to the cause(s)			
To the Hosp within 24 ho To the Fune completely f	Medical	29b. Signature and title of certifier	and manner stated.	29c. License numbe					
75 Wiring CO		Signature and the Of Certifier		D 63/99		9d. Date signed (Month, Day, Year)			
5 ε β		30. Name and address of person who	completed cause of death (Item 23a) (GIMER STERN SHO	Type Print)					
Sta		31. Date filed (Month, Day, Year)	32. Redistrar's Signature	1		,			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

06072 2009

	1- For State	Certifi	cate of Death	Reg. No.	0, 000.	
Physician			THE STATE OF THE S	2. Date of Death Month Pebruary 15, 2009 3. Time of Death 2126 hrs		
edical Examine	DIMPH - M		4b. City, Town, or Location of Deal			
	4a. Facility Name (if not institution, Franklin Square Hospit		Rosedale	Baltimore (County	
*Funeral		5. Sex 7. Age (In yrs. last b	pirthday) If Under 1 Year If Under 24H		. Birthplace (State or oreign	
Director		1 M 2 F 4	Yrs. Months Days Hours Mi	1 2-26-62	Country) MD.	
	Usual Residence of Decedent					
any	10a. State 10b. County		wn or Location		10d. Inside City Limits 1 Yes 2 No	
show	5 MD. BALTI	MORE	NOTTINGHAM	Lan Cili and Miles		
Maryland 28a-f show d at once	10e. Street and Number		10f. Zip Code	10g. Citizen of What		
h the]		BLVD. APT. 101	13. Was Decedent of Hispanic Origin? (Specify Ves or No. 14 Race - A	American Indian, Black,	
death with the Maryland r tiems 23a or 28a-f sh must be notified at once	11. Marital Status 1 Never Married 2 Ma	12. Was Decedent Ever in U.S. Armed Forces?	If Yes, specify Cuban, Mexican, Puer			
er dez		1 Yes 2 No	1 Yes 2 No specify:	Specify: 6	JhITE	
hours after inatural", o Examiner	15 Decedent's Education (Spec	or Dates:	Sa. Decedent's Usual Occupridon (Rive kind o during most of working life, DO NOT use n	of work done 16b, Kind of Busin	ess/Industry	
72 ho	Elementary/Secondary (0-12)	College (1-4 or 5+)	. 1	ourou,	. 11	
5-0036 led within 7 Hygiene. lother than	Elementary/Secondary (0-12) 17. Father's Name (First, Middle,		HOMEMAKER	me (First, Middle, Maiden Surname)	N HOME	
47 三田 二世			JOAN	. 11 1		
should be fi and Mental I 7 is marked natic event,	CLIFFORD B. BR 19a. Informant's Name/Relationsh	ANDENISCR4	19b. Mailing Address (Street and Number of	or Rural Route Number, City or Town,	State, Zip Code)	
and	Michael ROSSKOPF	SON	484 NORNEILE CT. GLE	NBURNIE, MD. 210	bl	
e, N I and Health item	20a. Method of Disposition		ce of Disposition (Name of cemetery, matory or other place)	Date 20c. Location - C	ity or Town, State	
MOre Pages I nent of I ant: If or other	1 Burial 2 Cremation 4 Donation 5 Other Sp	3 Removal from State		-20-09 HANONE	R. MD.	
Baltimore, M permit Pages I and 2 Department of Health Important: If item 2 injury or other traun	21. Synature of Funeral Service		22. Name and Address of Facility	hugherty Funera	H HOME	
ii Pere	Alxon		to not enter the mode of dying, such as cardia	DASADENA MD. Z	-1122	
Physician M dical	23a. Part I. Enter the also ase, or failure. List only one cause	on each line.		of respiratory arrost, errors, errors	Between Onset and Death	
xaminer	Immediate Cause (Final disease or condition resulting in death)	a. Oxycodone into Due to (or as a consequence of):	xication			
	Sequentially list conditions,	b.				
		Due to (or as a consequence of):				
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
ecuted and - transit		d#1 ac no	oted, 23a,PII,27,28a-	f.perME. 9890 4/2	2/09 TT	
<u>a a a</u>	X UNPENDED IF FEMALE:	X AMENDED #1 as IIC				
68760, certificate be ex nding physician se as the burial	- 123h was decedent bredhani ii ii	23c. If yes, outcome of pregna	ncy 2 Fetal death 3 Ectopic pre	23d. Date of congrancy Month	Day Year	
Sox 687 leath certifi	past 12 months? 1 Yes 2 No 9 V Uni Part II. Other significant condit	4 Pregnant at time of deat	2			
Box e death c the atten	1 Yes 2 No 9 V Uni	3 OHINIOWH		23e. Did tobacco use contrib	uite to the cause of death?	
G ta G ta	>	ions contributing to death but not res	ulting in the underlying cause given in Part I.		Probably 4 Unknown	
S, P. uires th	Cocaine use			24a. Was an 24b. W	ere autopsy findings available	
cords,	Completed			autopsy pr	ior to completion of cause of eath?	
Rec The la	E				✓ Yes 2 No	
tal Rec	25. Was case referred to medical examiner?		26.Place of Death (Cher. Other, Number 26.Place of Death (Cher. Number 26.Place of Death (Cher	eck only one) ursing Home 5 Residence 6	Other:	
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should la	o 1 Yes 2 No 27. Manner of Death	Impatient 2 V	ER/Outpatient 3 DOA Output 4 No. 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurre		
n of ' ding Ph h : After t	1 Natural 5 Pen	(Month, Dey,Year)	1 Yes 2 X No	unk		
Sior Attend r death ector: by the	2 Accident Inve	estigation FG 2/13/09 [1	Fd 8:46 pm me, farm, street, factory, office building, etc.	28f. Location (Street and Number or Town, State) 9512	r or Rural Route Number, City	
Division spital or Attendin hours after death meral Director: /	To the control of the	ermined (Specify) house		Nottingham, MD	relly half biv	
: B B B E		hysician: To the best of my knowledge	e, death occurred at the time, date and place,	and due to the cause(s) and manner	as stated.	
To the Host within 24 hc To the Fun	one) 2 Medical Exa	and manner stated.	d/or investigation, in my opinion, death occur			
F 3 F 8	29b. Signature and title of certifi	er	29c. License number	February 1	ed (Month, Day, Year)	
	Menjorie	me Kule	O.C.M.E.	rebluary li		
		n who completed cause of death (Item 2		MD 21201		
	Margarita Korell MD.	Assistant Medical Examine 32. Registrar's Signatur		2.201		
St	ate 31. Date filed (Month, Day, Year,		a st. d			

State of Maryland / Department of Health and Mental Hygiene 06073 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 200^{ye ar} **Physician** February 4:15 A M STERLING KATHLEENE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Somerset 31741 Peggy Neck Road Princess Anne Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 □ M 2 🖾 F 59 212-56-1275 June 11, 1949 Maryland Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Maryland Somerset Princess Anne 1 ☐ Yes 2 TrNo Director 10e. Street and Number 10f Zin Code 10g Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 21853 U.S.A. 31741 Peggy Neck Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 □Yes 2 ▼No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 🗵 No If Yes, Give Year or Dates: Specify: Specify: White 2 3 Widowed 4 X Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Laboratory Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental h Be Joan M. Somers Raymond Tom Sterling ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any Injury or other trau once. 28329 Crisfield-Marion Road -Marion Station, MD 21838 Sandy Kulley (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/13/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory nature fun rayService limitee Robert H. Bradshaw, Jr. 22. Name and Address of Facility
Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BIGGET CANCE letastatic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
□ Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 1 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy death? 1 ∐Yes 1 ☐ Yes 2 ☑ No 2 □ No. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only one) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) of certifier 29b. Signature and 0 0066198 30. Name and address (Operson who completed cause of death (Item 23a) (Type, Print) 18 Justinian Ngaiza, M.D. - 100 E. St. Carroll - Salisbury, MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 10, 2009 **Physician** James I. Shultz 5:15A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cherry Lane Nursing Center Laurel Prince George's 8. Date of Birth OCT. 23, 1919 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months Hours 160-16-2401 1**X** M 2□ F 89 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Maryland Prince George's College Park 1 XYes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be no once. 7308 Edmonston Road 20740 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1
Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No \$ Specify: Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry
National Institute of 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chemist Science and Technology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alvin Shultz Cora Quickel ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy R. Shultz -wife 7308 Edmonston Road College Park, Maryland 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBuria! 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cem. 2/14/2009 | Adelphi, Maryland 21. Signature of Funeral Tervice L. enses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mĭll Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer of the Tongue /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ours after death. Heral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension; Anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops 2 **Z**No 1 ☐ Yes 2X No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2∏ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 14 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a, Certifier 1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D45217 February 10, 2009 nploted cause of death (Item 23a) (Type, Print)
D. 6201 Greenbelt Road College Park, Maryland 20740 30. Name and adds

State Registrar

31. Date filed (Month, Day, Year) 11 2009

'Ajayi

Ade Isago

M.D.

Registrar's Signature

			1 - For State of Maryland / Do	epartment of H Certificate of I	Death	Reg. No.2	009 06075
	Physicia	an	1. Decedent's Name (First, Middle, Last)		Mo	e of Death nth Day ruary 5,	3. Time of Death 2009 10:45 p M
	/Medic	al	Ruth D. Siegelbaum 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	r Location of Death		2009 10:45 p ^M ounty of Death
	Examini	ici	Hebrew Home of Greater Washington	Rocky		Me	ontgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year Months Days	Hours Min. (Mc	e of Birth onth, Day, Year) . 4, 191	9. Birthplace (State or Foreign Country) 2 Germany
	Director		064-16-3409 X 96		рес	. 4, 191	Z Germany
ncs	ryland how		10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
Olim	8a-fs	Director	TEGETIZE TO THE TEGET	Church		10 0:::	1 Tyes 2 No
107 11	with th	ă	10e. Street and Number	10f. Zip Code 22046	5		en of What Country? U. S. A.
	ms 23	Funeral	414 Great Falls Street 11. Marital Status 12. Was Decedent Ever in U.S.		lispanic Origin? (Specify Ye an, Mexican, Puerto Rican,		Race - American Indian,
9	after o		1 Never Married 2 Married If Yes, Give	1 ☐ Yes 2 No	Specify:		Black, White, etc. Specify: White
9	hours tural",	d b	3 KJ Widowed 4 LJ Divorced Year or Dates:	Decedent's Usual Occup	ation		of Business/Industry
75	iin 72 n "nat	plete	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done life. DO NOT use retired	during most of working		ork Highway
212	d with	Completed by	2 Years	Clerical			Department
pur	be file tal Hy ed oth event	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name (First,		urname)
<u> </u>	hould ad Mei marke matic	٩	Jakob Lowenstein 19a. Informant's Name/Relationship (Type. Print) 19b. 1	Mailing Address (Street	Dina St		Town, State, Zip Code)22046
Z	nd 2 s alth ar 27 is						rch, Virginia
什 Baltimore, Maryland 21215-0036	es 1 a of He of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of I cemetery.	Disposition (Name of crematory or other place	Date	20c. Loca	ation - City or Town, State
Ĕ	t. Pag tment tant: I		4 □ Donation 5 □ Other (Specify) Mount	Lebanon			endale, New York
于 Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Item World Extensive mast keep office at once.		21. Signature of Funeral Service Licensee		ss of Facility el Funeral D:		
7			23a. Part1. Enter the disease, or complications that caused // death. Do no shock, or heart failure. List only one cause on each line.	11091 Rockv ot enter the mode of dyi	ille Pike, Rong, such as cardiac or respi	ratory arrest,	Maryland 20852 Approximate Interval Between
R	Physician		Immediate Cause (Final disease or condition	IEUMO	NIA		Onset and Death
	/Medical Examiner		resulting in death) a. Due to (or as a consequence of):		- 11-	
Z		ē	Sequentiary list conditions, If any leading to immediate Due to (or as a consequence of	1211/001	ORGAN	151115	
2	executed n and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,			
W.O.	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of	f):			
S 28	cate b	dical	d				
DX O	certificate nding phys use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23	3d. Date of delivery
Pa	death e atter	sicial	in the past 12 months? 1	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су 		Month Day Year
110	that the ed by th detache	Phys	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause di	ven in Part I	le. Did tobacco use	e contribute to the cause of death?
Sp	uires sign d be	d by	DEMENTIA OF ALZ	HEIME	RS TYPE	1 □ Yes 2 □	No 3 Probably 4 Unknown
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	law req as beer 2 shou	Completed	7 6		24	a. Was an	24b. Were autopsy findings available prior to completion of cause of
Ä	The la	Som			1[autopsy performed? Yes 2 100	death? 1 Yes 2 No
Vita	Physiclan; r this certific	Be (25. Was case referred to medical examiner?	Ott	26. Place of Death (Chec		
o to	Phys r this eral dir	7:To	27. Manner of Death 28a. Date of Injury 28b. Ti	me of 28c. Inju	4 Nursing Home 5	Residence 6	
<u>io</u>	Attending r death. ector; After by the fune	atior	Natural 5 □ Pending (Month, Day, Year) In 2 □ Accident investigation		k? lYes 2□No		
Sivision of Vital Recor	or Atte	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farr building, etc. (Specify)	m, street, factory, office	28f. Lo	cation (Street and by or Town, State)	Number or Rural Route Number,
	Hospital of the state of Funeral Distribution of Funeral Distribution of the state	Ce	29a. Certifier Certifying Physician: To the best of my knowledge,	death occurred at the t	ime, date and place, and du	e to the cause(s) a	and manner as stated.
	the Hos hin 24 hd the Fun mpletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.				
	Vithir Comp	Me	29b. Signature and title of certifier	29c. Licens	se number	29d. Date	signed (Month, Day, Year)
	10		1 / her tell my		018084	1 FE	SKLIARY US, 200 9
	,		30. Name and address of person who completed cause of death (Item 23a) (7	Type, Print)	ON TROISE	20,10	CKVILLEMD ZU XSZ
	Sta	ate	31. Date filed (Month, Day, Year) FEB 10 2009 32. Registrar's Signature	parker		7.	/
	Regist	rar	FED I U 2003 Strawn B.	garre			

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H <i>rtificate of l</i>			iene _{eg. No.} 200	9 06076
	Physicia	an	Decedent's Name (First, Middle, La Fdward Sylvan She:					2. Date of Deat Month February	h	3. Time of Death
mar.	/Medic Examin		4a. Facility Name (If not institution, given			4b. City, Town, or	Location of Death		4c. County of De	eath
			Montgomery General 1			Olney If Under 1 Year	If Under 24 Hrs.	O Date of Birth	Montgomer	
b	Funeral Director			Sex 7. Ag 1 🔀 M 2 🗆 F	e (In yrs. last birthday) 89 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct. 12,	Year) 1919 Was	irthplace (State or Foreign Country) Shington, DC
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Man	ctor	Maryland Monte	gomery	Silver S	pring				1 ☐ Yes 2 🔀 No
	with th	Dire	10e. Street and Number	***		10f. Zip Code 2090	•	1	0g. Citizen of What 0	Country?
	ms 23	Funeral Director	3612 Chorley Woods 11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of H		pecify Yes or No-	14. Race - Ar	nerican Indian,
36	be filed within 72 hours after death with the Maryland tial Hyglene. do other than "natural", or items 23a or 28a-f show event, I'm "Adfral Exen inc.", ust be natified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? IMAYes 2 □ I If Yes, Give Year or Dates:	No.	1 ☐ Yes 2 K No	Specify:	nican, etc.)	Specify: Wh	·
2-00	2 hour	ted I	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation	ring	16b. Kind of Busines	
21215-0036	- 3	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	life	DO NOT use retired	naming most or work	ing	Governm	ent
d 2	filed v Hygie other t	Be Co	17. Father's Name (First, Middle, Las	1)		Highleen	18. Mother's Nam	e (First, Middle, M		enc
Maryland	ould be Menta arked	70 B	Sylvan A. Sheridan					Le Morgan		
Mar	nd 2 sh alth and 27 Is m r traum		19a. Informant's Name/Relationship Christine Sheridan B		T T				; City or Town, State Le, MD 20850	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, In any longe.		20a. Method of Disposition 1 A Burial 2 Cremation 3 4 Donation 5 Other (Speci		20b. Place of Dispo cemetery, createry, createry, createry	matory or other plac	Feb.	11,	20c. Location - City of Brentwood,	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Lice		2	2. Name and Address Francis J. 9 500 Univers	ss of Facility	neral Home	Inc. r Spring, MD	20901
			23a. Part Enter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each li	the death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- u	e Heart Block	k				Oriset and Death
and the same	Examiner				a consequence of): cular Fibrill	ation				
	led isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of):					
, 00	iicate be executed physician and s the burial-transit	l Examiner	resulting in death) Last	c. Acute N Due to (or as	fyocardial In a consequence of):	farction				
58760,	ficate by physic s the b	edical	,	d						
Box	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death 3	☐ Ectopic pregnanc☐ Other (specify) _	у		23d. Date of o	delivery Day Year
P.O.	at the de by the tached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 ☐ Unknown						
of Vital Records, I	quires that an signed I uld be deta	<u>م</u>	Part II. Other significant conditions Anoxic Encephalopath	contributing to death by, Dementia,	ut not resulting in the u Hypertension	inderlying cause giv , Renal Fai	en in Part I. lure			to the cause of death? Probably 4 🗓 Unknown
eco	e law requir has been s e 2 should	Completed						24a. Was a	v prior t	autopsy findings available o completion of cause of
al B	stcian: The certificate hi rector, page		05 W							? es 2 □No
ī Vit	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 ER/Outpatie	nt 3 DOA Oth		th <i>(Check only on</i> ome 5 ☐ Reside	<i>e)</i> ence 6 □Other <i>(Si</i>	pecify)
0 U	ding Ph h. After th funeral	ion: T	27. Manner of Death 1 ★ Natural 5 Pending	28a. Date of Inju (Month, Da	y, Year) 28b. Time o	Worl	y at		ow injury occurred	
Division	or Attending Physician: The law requires that the death certificator death: Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of Inj	ury - At home, farm, st c. <i>(Specify)</i>	1	Yes 2□No	28f. Location (St City or Town	reet and Number or n, State)	Rural Route Number,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	Medical Ce	29a. Certifier (Check only one) Check only one)	miner: On the basis of	of my knowledge, deal	th occurred at the til	me, date and place	, and due to the c	ause(s) and manner late and place, and d	as stated. lue to the cause(s)
	To the within ?	Мео	29b. Signature and title of certifies	and manner st	aleU.	29c. Licens	e number	2	9d. Date signed (Mo	nth, Day, Year)
	20+1		Mulas	V(st	- MA	6-	7136		2/9/0	9
			30. Name and address of person who Michael Castine, MD		leath (Item 23a) (Type,		, MD 20832		1.1	
	Sta	_	31. Date filed (Mont/FLB/B'eat) 0		ar's Signature					
	Registr	ar			/ //	and the second second				

DHMH 17 Rev 1/2001

		For State	State of	f Marylan			of Heal		Mental H	ygien Reg. No	2000	06077
		Registrar 1. Decedent's Name (First, Middle	l ast)			incati	OI DCG		2. Date of D		200.	3. Time of Death
Physicia	an	-	_		G1 1				Month	Da	y Yea 5, 2009	r
/Medic		George F1 4a. Facility Name (If not institution	ancis	mhar)	Snask	an,	Town, or Local	tion of Death			County of De	
Examin	ier											
Funeral		5610 Wisconsin 5. Social Security Number		7. Age (In yrs.	last birthday)	If Under		nder 24 Hrs.	8. Date of B	irth	ontgome 9. B	irthplace (State or Foreign
Funeral Director		060-14-3544	1 ⊠ M 2□ F	91	Yrs.	Months	Days Ho	urs Min.	07/31	/191	7 Ne	country)
ъ		Usual Residence of Decedent										
how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d, Inside City Limits
a-f s	cto	Maryland Montgo	mery	Chev	y Chas	se						1 X Yes 2 □ No
or 28	Dire	10e. Street and Number				10f. Zip					itize <i>n</i> of What (
23a	Funeral Director	5610 Wisconsin				208						es of Americ
be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Modical Examinar met be notified at	nne	11. Marital Status	Armed Fo		S. 13.	Was Deced If Yes, spec	ent of Hispani ify Cuban, Me	ic Origin? (S exican, Puert	pecify Yes or No Rican, etc.)	lo-	Black, Wh	
s afte	by F	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv	ve		1 □Yes 2	No Spe	ecify:			Specify: Wh	nite
tural'		15. Decedent	Year or Da	ates: WWI]	1	dent's Usua	Occupation			16b. h	Kind of Busines	ss/Industry
n 72 n "na n edic	Completed	(Specify only highes	st grade completed)		(Give	kind of wor DO NOT us	k done during e retired)	most of wor	king			
withi	m o	Elementary/Secondary (0-12)	College (1	-4or 5+)		Inves	tment A	Adviso	r		Fina	ncial
filed I Hyg other ent,	Be C	17. Father's Name (First, Middle,	Last)				18. 6	Mother's Nar	ne (First, Middi	e, Maide	n Surname)	
ld be lenta ked lc ev	To B		George Sha	askan					Fa	nnie	Luber	
shound N	-	19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address	(Street and A	umber or Ru	ural Route Num	ber, City	or Tayya State	e, Zip Code)
nd 2 alth a 27 is		Myra Hellman	Shaskan, T	Wife			Chevy	Chase	e, Mary	land	20815	•
s 1 a of He othe		20a. Method of Disposition	_	20b. F	Place of Dispo	sition (Nan	ne of	1	Date	20c. L	ocation - City	or Town, State
Page int: #		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State Gard	emetery, crer len of Memori			02/0	06/2009	Cla	rksburg	, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar mast be notified at once.		21. gnalung ul Faneral Service			22	2. Name an	d Address of I	Facility				
Per B Per B		(Am)			110	iwara 191 Ro	Sage1 ckvill	e Pike	ai Dire e. Rock	ctio vill	n, Inc. e. Marv	land 20852
		23a. Part 1. Enter the disease, or									, , ,	Approximate Interval Between
Physician	X i	shock, or heart failure. List Immediate Cause (Final										Onset and Death
/Medical		disease or condition resulting in death)		opulmor		rest						5 Minutes
Examiner			Coron	ary Art	erv Di	sease	2					10 Years
	ē	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	D. Que to r	(or as a nonseo	uence of):							
be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events	c. Ather	osclero	sis							20 Years
an ar rial-tı	E	resulting in death) Last		(or as a consec								
cate be executed physician and the burial-transit	dical		d									<u> </u>
The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Jed	IE EEMALE.										
eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregnation birth 2 Feta		☐ Ectopic p	regnancy			1	23d. Date of	
dea death	Sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of		Other (sp				.	Month	Day Year
at the	, h	9 Unknown							1			
uires that the de signed by the a d be detached to	by	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	nderlying c	ause given in	Part I.				to the cause of death?
w requir s been si should I									1 [_Yes 2	2 (2 1 No 3 ∐	Probably 4 Unknown
as be	ple								24a. Wa	as an topsy	24b. Were	autopsy findings available to completion of cause of
The ate h	Completed								pe 1 □ Yes	formed?	death	
sician: The law certificate has t irector, page 2 s	Be C	25. Was case referred to medica					26.	Place of De	ath (Check only			
Physician: r this certific ral director,		examiner? 1 X Yes 2 ☐ No	Hospital: 1 □	Inpatient 2	ER/Outpatie	nt 3 🗆 D0	Other: 4	☐ Nursing I	Home 5 Re	sidence	6 ☐ Other (S	pecify)
ding Phy h. After thi funeral o	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date	of Injury oth, Day, Year)	28b. Time o Injury	of 2	8c. Injury at Work?		28d. Describ	e how inj	ury occurred	
tendil death. tor: A the fu	atic	2 Accident investi	gation			М	1 ☐ Yes	2 □No				
r Atte	l≌	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	singer 28e. Place	of Injury - At hing, etc. (Speci	ome, farm, sti fy)	reet, factory	, office			(Street a		Rural Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, the funeral director.												
lospi t hou uner	ledical	29a. Certifier (Check only 2 Medical	ng Physician: To the Examiner: On the b	e best of my kno	owledge, dear	th occurred	at the time, d	ate and place	e, and due to thur to the time.	he cause le, date a	(s) and manner and place, and c	r as stated. fue to the cause(s)
To the Hos within 24 hd To the Fun completely	ledi	one)	and man	ner stated.								
Vith Vith Com	Σ	29b. Signature and title of certifie	On.	AVI	7 -		:, License nun +398 DO					onth, Day, Year)
26		Lawrence	e Elho	t N	Lem	1	D(rebr	uary 5,	, 2009
d)		30. Name and address of person Lawrence Ellio	who completed caus	se of death (Ite	m 23a) (Type,	Print)	re. Ret	thesda	Marv1	and	20817	
				,		. DII	, Det		, maryı		20017	
Sta Registi	ate	31. Date filed (Month, Pay, Year)	0 2009 32. 5	Pegistrar's Sig <i>n</i>	ature .	bords	,					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 06078 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sefekar Thelma February 2009 22:50 P^M 3, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 □ F Director 89 066-01-6950 Jan. 16, New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 De Yes 2 □ No Director Florida Pinellas Palm Harbour 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 750 Helmsman Way 34685 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Wellon Exercing 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No þ White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Bank Teller 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Lakoff Bessie Kantor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Sefekar - Husband 750 Helmsman Way Palm Harbour, Florida 34685 20b. Place of Disposition (Name of cemetery, crematory or other place)
Curlew Hills Memory
Gardens 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb. 6, 20**0**9 Palm Harbour, Florida 22. Name and Address of Facility 21. Signature of Funeral Service License Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the wath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** /Medical **Examiner** attending physician and for use as the burial-trae Physiclan/Medical signed by the d ğ Completed Be ၉ Certification:

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After this certificate funeral director, pag

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Oue to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ₩0 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy gridings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No	26. Place of Death (Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	Check only one) ⇒ 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death N Natural 5 ☐ Pending 2 ☐ Accidentinvestigation		d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1X Certifying Phy 2 Medical Exam	sician: To the best of my knowledge, death occurred at the time, date and place, ar iner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number D 6 D 1 D	29d. Date signed (Month, Day, Year)
30. Name and address of person who co	completed cause of death (Item 23a) (Type, Print)	al Haenital

State

Medical

State of Maryland / Department of Health and Mental Hygiene Reg. No. UU Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year FEBRUARY 14, 2009 **Physician** 0550 A M MOTES SMITH EVELYN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CHESTERTOWN KENT HERON POINT 8. Date of Birth (Month, Day, Yea 12/3/1920 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex Days Hours **Funeral** Months 1 M 2 F 88 423-10-9165 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State X Yes 2 No CHESTERTOWN Director KENT MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21620 209 HERON POINT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2√☐ No Specify: Baltimore, Maryland 21215-0036 Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) EDUCATION TEACHER 12 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FLOY MCCORD ELLIS WREN MOTES မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 100 WEST UNIVERSITY PKWY BALTIMORE, MD 21210 WARREN SMITH/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/17/09 STEVENSVILLE, MD 4 Donation 5 Dother (Specify) CHESAPEAKE CREMATION 22. Name and Address of Facilit 21. Signature of Funeral Service Licenses HELFENBEIN & NEWNAM FUNERAL HOME FELLOWS, HELFENBEIN & NEWNAM FUNERAL 130 SPEER RD. CHESTERTOWN, MD 21620 Kill 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ATHEROSCLEROTIC CARDIOVASCULAR DSEASE Immediate Cause (Final near **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se wentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as the t for use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death Month Day Year in the past 12 months? 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BIPOLAR DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an DEMENTIA autopsy perfore death? 1 □ Yes 2 No GENERAL FRAILT 212 No 1□ Yes Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3□ DOA မ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a e Funeral I Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D004158 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) speer Rd. Chestertown, MD 21620 A Noble, MD 122 Helen 32. Registraris Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6:45 PM FebUARY 2009 Ruth Anne Shaffer 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Washington County Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Oct. 13,1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 76 Oct. Ohio 206-24-3688 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Marvland Washington County Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 10114 Sharpsburg Pike U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🗓 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Church Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elta Pauline Schroy Roach Harry Robert Roach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Rae-son-in-law 615 Green Valley Rd. York, PA 17403 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 2-21-2009 Apollo, PA Riverview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licens 1331 Eastern Blvd. North Hagerstown, MD 21742 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final Chronic mielomorocytic yeurs disease or condition resulting in death) Due to (or as a consequence of): own

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinet must be notified at

12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r

of Health a

If item 27 is

Pages 1 Department of Important: If it any Injury or o

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

and burial-tran attending physician as the l sate has been signed by page 2 should be detact : After this certific funeral director, this

Attending Physician: The law requires that the death certificate be executed

death.

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Completed Be Certification: To To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Sequentially list conditions, Large Large Large Large Sause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	b. Due to for as a consequence. Due to for as a consequence.		,			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 🗆 Ectopic p			23d. Date of delivery Month Day Year	
Part II. Other significant conditions of	ontributing to death but not rest	ulting in the underlying c	ause given in Part I.		use contribute to the cause of death	
				24a. Was an autopsy performed? 1 □ Yes 2 🗷 No	24b. Were autopsy findings avail prior to completion of cause death? 1 □ Yes 2 □ No	
25. Was case referred to medical			26. Place of De	ath (Check only one)		
examiner? 1 ☐ Yes 2 ⊠ No	Hospital: 1 ♣ Inpatient 2 □	ER/Outpatient 3 DO	Other: 4 Nursing I	Home 5 ☐ Residence	6 ☐ Other (Specify)	
27. Manner of Death 1 ★ Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	8c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inju	ry occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Fig. City or Town, State)					
				1		

29a. Certifier

(Check only one)

Medical

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number D45813 29d. Date signed (Month, Day, Year) Feb 16 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

11110 medical Campus Road Hagerstown, MD 21742 Egner MO. 31. Date filed (Month, Day,

State Registrar

05H-10



State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** DUDITH ANN SCHOOLMAN Eberney 9 2009 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death. Examiner PENINSULA REGIONAL Cent SALISOURY HIOMM 100 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex . Age (In yrs. last birthday) **Funeral** Min. Davs Hours Months 217-40-6806 1 □ M 2 ▼F 67 Director MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ilmportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Modoral Exercises must be could as any enough. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 No Funeral Director TYASKIN MD Micomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21865 TYASKIN NAUTIOCKE RD AZU 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNED HOME 10 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BERTHA WIFFIN JAMES W SUBSSE ဥ 1ga. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SCHOOLMAN SR WUSBAND 20b. Place of Dispositon (Name of cemetery, crematory or other place) TUASKIN MB AUSES

20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State SALISBURY, MED SALIS RUDU CTEMA TORY
2. Name and Address 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MESSIEK FUNETAL HOME PO BOXGI BIVALVE IND Immediate Cause (Final **Physician** VD resulting in death) /Medical Due to (or as a consequence of) Examiner Mellita riofetto Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physiclan and ned for use as the burlal-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed after death.

Director: After this certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Watural 1 ☐ Yes 2 ☐ No 2 Accident illed in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifique 29c. License number 29d. Date signed (Month, Day, Year) 63199 69 101 30. Name and a ess of person who completed cause of death (Item 23a) (Type, Print) EAST ERN VOHRA SHOR SALISBURY, 31. Date filed (Month, Day, Y Year) State 11 Registrar

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Direc permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "Important: If them 27 is marked orther than "natural", or thems 23a or 28a-7 show any Injury or Arbe Vanime in some in the second of the training or Arbe Vanime.

Baltimore, Maryland 21215-0036 Physici /Medi Exami

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and commission will all in by the internal director made 3 should be detached for use as the british transit Division of Vital Records, P.O. Box 68760,

	1	1 - State Registrar	Cer	tificate of	Death	Reg	g. No. 2009	06082				
		1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death				
sicia edica		Kaeko Smith				Feb 6,	2009	6:45 A ^M				
mine		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	th				
		13120 Tobacco Trail		Brand				George's				
ral		5. Social Security Number 6. Sex 7. Age (In yrs. In		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign puntry)				
tor		139 30 8353 X //	Yrs.			March :	3, 1931	Kobe, Japar				
	1	Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Loc	eation				10d. Inside City Limits				
20.00	5							1 ☐ Yes 2 ☐ No				
	Director	Maryland Prince George Br	andywi	10f. Zip Code		10	g. Citizen of What Co	A				
		13120 Tobacco Trail Lane		·	0	1		,				
	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	S 113 V	2061	. 3 Hispanic Origin? (Sp		United Sta					
2	ᇤ	Armed Forces?	in in	Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, Whit					
9	কু	1 □ Yesr Married 2 □ Married 1 □ Yesr 2 □ X You If Yes, Give Year or Dates:	1	□Yes 2 XX	Specify:		Specify: Jar	oanese				
	Completed	15. Decedent's Education	16a. Deced	ent's Usual Occu	pation during most of work	10	6b. Kind of Business					
NAME OF THE OWNER, OWNE	e d	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. E	OO NOT use retire	during most of work ed)	ing						
200	5	12	House	wife			Own Home					
	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		-					
	၉	Sankite Miyamoto	T		Mote	(UNKNOWN))					
		19a. Informant's Name/Relationship (Type. Print)					City or Town, State,					
		Alan Smith (SON)					ndywine, M					
ury or ou		1 Burial 2 Li Cremation 3 Li Removal from State _		sition (Name of natory or other pla			Oc. Location - City or					
ılııy				_	b 12, 200		Clinton, M					
once		21. Signature of Funeral Service Ligensee					Home, Inc					
	_	23a. Part 1. Enter the disease, or complications that caused the death					nton, MD 2	2U / 35 Approximate				
		shock, or heart failure. List only one cause on each line.	i. Do not ente	si tile illode oi dy	ing, such as cardiac	or respiratory arre-	51,	Interval Between Onset and Death				
ian		Immediate Cause (Final disease or condition resulting in death)	2120	8+	Viver							
cal ner		Due to (or as a consequence of):										
	ē	Sequentially list conditions, bb	uence of):									
	Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	,									
ds the Dunal-traffs	Exa	resulting in death) Last	uence of):									
200	cal	d										
200	Medical						1					
		IF FEMALE: 23b. Was decedent pregnant in the post 12 months? 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Feta	incy	Ectopic pregnan	101		23d. Date of de					
0	/sician/	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of o		Other (specify)			Month	Day Year				
lacin	Phys	9 Li Unknown										
e de	by	Part II. Other significant conditions contributing to death but not rest	ulting in the ur	nderlying cause gi	ven in Part I.			to the cause of death?				
pino		Hypertonsion				1 🗆 Ye	s 2 No 3 □ F	Probably 4 Unknown				
200	Completed	Anom 19				24a. Was an autopsy	prior to	utopsy findings available completion of cause of				
bad	Con					perform	ied? death?	s 2 No				
actor,	Be (25. Was case referred to medical examiner?				th (Check only one)					
E	ပ		ER/Outpatier	IL 3LI DOA		11.71	nce 6 Other (Sp.	ecify)				
inue	ion	27. Manner of Déath 1 Deatural 5 ☐ Pending (Month, Day, Year)	28b. Time of Injury	Wo	rk?	28d. Describe how	w injury occurred					
e 2	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of Injury At the	amo form etc]Yes 2 □No	29f Location (Ct-	reat and Number or F	Pumi Bouto Mumbar				
ipietely filled in by the luneral director, page z strould be detached for us	Certification:	4 ☐ Homicide	y)	eet, lactory, office		City or Town,	eet and Number or F , State)	iurar noute Number,				
Tilleo		29a. Certifier 1 Certifying Physician: To the best of my kno	wledge, deat	h occurred at the	time, date and place	and due to the ca	ause(s) and manner	as stated.				
ietely	Medical	(Check only 2 Medical Examiner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my	opinion, death occu	rred at the time, da	ate and place, and du	e to the cause(s)				
dimos	Me	29b. Signature and title of certifier		29c. Licer	nse number		9d. Date signed (Mor					
		pmg		DI	16478		2-6-21	309				
		30. Name and address of person who completed cause of death (Item	n 23a) (Type,									
>		Suresh A Patelmo	75	DI Su	18821ts	Rel C	inton	mD20735				
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signal	ture	1		,						
gistr	ar	FEB 1 1 2009 Revenue	1. 4	parke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	,	Certificate	of Dea	th			R	eg. No.	201	JJ	0000
Physicia	an/	1. Decedent's Name (First, Middle, Last							Date of Dea Month		Year		Time of Death
edical Exami	ner	Roberta Marie		<u>-</u> .	T				ebruary	Day 15, 2009	-4: -4 D		2130 hrs
		4a. Facility Name (if not institution, give Sandy Point State Park	e street and number)			, Town, or Lo apolis	ocation of I	Death		4c. County of Death Anne Arundel			
Funeral Director		5. Social Security Number 6. Se 216-60-1524 1	x 7. Age (In	yrs. last birthday 56	Mor	ths Days	If Under 2 Hours	Min		th(MM/DD/Y	1 _{Fo}	reign	ace (State or Tyland
		Usual Residence of Decedent	M ZAF	50	YTS.				Dec .	1 1 1 3	32	OPICE	Lylana
any	ŀ	10a. State 10b. County		. City, Town or Lo									d. Inside City Limits
nd show	_	Maryland Anne A	rundel	Annapo	lis							1	X Yes 2 No
laryla 28a-f	Director	10e. Street and Number			10f. Z	ip Code			1	0g. Citizen o	f What (Country	?
the M a or 2 tiffed		1228 Tyler Ave				21401	l			U	SA		
with ms 23	era	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.		dent of Hisp cify Cuban,					Race - Ar White, et		Indian, Black,
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tani: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X			2 X No		donto i viol	un, oto.)	Spec		B1a	ck
irs afte	ò	15. Decedent's Education (Specify or	or Dates:			al Occupatio		nd of work	done	16b. Kind	of Busine	ess/Indu	ıstrv
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	9th	0		Cust	odiar	า			Sch	001	Во	ard
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d be filental arked vent,	a	Charles Enoch		Lagua			_		Jacks		-		
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	٢	19a. Informant's Name/Relationship (T Rosemary Grave	•			ss (Street 1er <i>1</i>				nber, City or			
and 2 lealth Item 2		20a. Method of Disposition		20b. Hace of Dis	@311 @ 83	ne of cem			ate	20c. Loca			
Baltimore, permit Pages I an Department of Hea important: If iten		1 X Burial 2 Cremation 3		Memori	rotherplac a1 G	_{e)} arder	ns	2-2	6-09	Ann	apo	lis	, Md.
ortan		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licen		2	¼/ma me a	Rees	≨ Fa § ility S	Sons	Mor	tuary	, P	. A .	
Dep Der Injurial			Mc0483		821	West	St.	Ann	apol:	is, M	d.		01
Physician		23a. Part I. Enter the disease, or comp failure. List only one cause on ea	lications that caused the	death. Do not en	er the mod	e of dying, s	uch as car	rdiac or re	spiratory an	rest, shock, o	r heart		Approximate Interval Between Onset and
Medical xaminer		Immediate Cause (Final disease a.	Drowning										Death
		or condition resulting in death)	Due to (or as a conseque	ence of):									
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Box 68 death certif the attending	Physician	1 Yes 2 V No 9 Unknown		e or death 5	Other (S	ресіту)				35365			
tal Records, P.O. Box 68 cian: The law requires that the death certificate has been signed by the attending ector, page 2 should be detached for use as		Part II. Other significant conditions	contributing to death bu	t not resulting in t	he underly	ng cause gi	ven in Part	t I.	23e. Did 1	tobacco use	contribut	te to the	cause of death?
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1 of Jing Ph After funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time	of Injury		at Work?	28 S1	d.Describe ubjeci	how injury of t jump	$\operatorname{ed}^{\text{courred}}$	rom	bridge
SiOr Attent death death sector:	cati	2 Accident Investigati	on 2/15/09	8:45					f Location	(Stroot and N	lumbore	or Bural	Route Number, City
Division of Vital Records, pital or Attending Physician: The law require ours after death ereal Director: After this certificate has been similed in by the funeral director, page 2 should be	Certification:	3 X Suicide 6 Could not determine	d (0 15)		street, racti	ory, onice bu	anding, etc.		or Town,	State)Che Lis, M	sape	ake	Bay
lospit 4 hour 3 uners		4 Homicide 29a. Certifier 1 Certifying Physic	an: To the best of my kn	bridge owledge, death o	ccurred at	the time, dat	e and plac					stated.	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical		On the basis of examination										ause(s)
F § F 8	Me	29b. Signature and title of certifier	aria marinor otatoa.	,		29c. License	number			29d. Date	signed	(Month	, Day, Year)
		2n	M. 16	•		O.C.N	1.E.			Februa	ry 16,	2009	
			completed cause of deat Chief Medical Exar		Penn Sti	eet, Balti	more M	/ID 2120)1				
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State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February I, 2009 **Physician** 17:45 Darne11 С. Studevant /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Montgomery General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 → M 2 □ F 56 579-72-7119 Director Nov 21, 1952 Washington, DC Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Examinar must be neultified at once. 1 Yes 2 □ No Director District of Columbia Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20019-1643 United States 3515 Jay Street, NE #203 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Completed by 3 Widowed 4 Divorced African American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Government (DCHA) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary L. Wingo 2 Eldevan Studevant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Studevant - Mother 3515 Jay Street, NE #203 Washington, DC 20019 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory Feb 16, 2009 Clinton, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sint ture of Funeral Servi Licensee 4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Cardia richte /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ff as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2. No 1 ☐ Yes 2 ☐ No 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. Med Brok 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Prome Philip S- , Olary 20832 31. Date filed (Month, Day, Year) State FEB 1 3 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 19 2009 ELMER CLAY SELLS FEBRUARY 10:000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Elkton Cecil 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Sept 24 1935 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months 1 MM 2 ☐ F 73 215-32-8525 NC Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 No be notified Director MD Kent Galena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 105 Ashwood Lane 21635 U.S.A. 'natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 No 1957

If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: -1961Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Industrial Elementary/Secondary (0-12) College (1-4or 5+) Heating Boiler Maker 12 l and 2 should be filed w lealth and Mental Hygie m 27 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Raymond Sells Golda Hilda Pollard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Item 27 in any Injury or other tra Sally M. Sells (wife) 105 Ashwood Lane Galena, MD. 21635 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Department of 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Kent Cremation 2/21/09 Smyrna, DE. 5 ☐ Other (Specify) of Hundral Sarvice License 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech M00510 118 West Cross St. Galena, MD. 21635 Rant. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Qo not enter the mode of dying, such as caretjac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed burial-tra Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month ŏ 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 3 No 3 Probably 4 ☐ Unknown 1 ☐ Yes icate has been significate has peen significated to be a should to be a should to be a should to be a significant to be a sign Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes '2 No 1 Inpatient 2 ER/Outpatient 3 DOA ို this funeral 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural
2 Accident 5 Pending investigation (Month, Day Year) neral Director: A 1 Yes 2 No death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide after within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2192 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) mt

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DIL

State Registrar 201in

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygienes 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 20 2009 **Physician** MARY POLLARD STIPA 9:25a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital Elkton Cecil | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F 85 New Jersey 216-28-2248 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show idiçal Examiner must be notified at Director 1 X Yes 2 No MD Cecil Cecilton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 221 W. Main St. 21913 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Be Completed by Specify: White 3 XWidowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Pollard Laura Morgan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Wordsworth Dr. Wilmington, DE. 19808 Mary Schweiger (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Stephen's Cem. 2/26/09 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Earleville, MD. 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Galena Funeral Home of Stephen L Schaech
118 West Cross St. Galena, MD. 21635 21. Signature of Funeral Service License M00510 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or condition resulting in death) epsis 6I 14 Physician = 2440V1 /Medical Due to (or as a consequence of): **Examiner** 3 d =45 6 astrolyteritis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Physician/Medical Examiner or Attending Physician; The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dehydration 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Alzheiner, Decreyt 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform After this certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day Year) s after dea... 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 20,2009 DO055180 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Mospital 106 Bow Street Elkfor MD 21921 149 Afred A 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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		1	For State Registrar	State of Ma	aryland		artment of F <i>rtificate of I</i>	lealth and N D <i>eath</i>		giene Reg. No. 2	009	06087		
			1. Decedent's Name (First, Middle, Las	st)					2. Date of De Month	ath Day	Year	3. Time of Death		
	Physicia	_	Hai Van Tran						Februar		2009	3:45 P M		
100	/Medic Examin	_	4a. Facility Name (If not institution, give	e street and number)	****		4b. City, Town, or	Location of Death		4c. Co	ounty of Death			
	Examin	·	Shady Grove Adver	ntist Hosp	ital		Rockvil				ntgomer			
	Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year)	Cou	place (State or Foreign intry)		
	Director		217-25-7725	[X M 2□ F	92	Yrs.			02/24/	1916	Vie	tnam		
	D >	-	Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Lo	cation					10d. Inside City Limits		
	aryla sho	ō	,									1 X Yes 2 No		
	he M	Director	MD Montgome 10e. Street and Number	ery	Gai	thers	10f. Zip Code		1	10g. Citizei	n of What Cou	intry?		
	a or		390 North Summit	Arronio #1	01		2087	7	Ì	Unit	ed Sta	tes		
	filed within 72 hours after death with the Maryland Hyglene. Hygle	Funeral	11. Marital Status	12. Was Decedent		. 13.	Was Decedent of H		pecify Yes or No		. Race - Amer	ican Indian,		
"	ter d riter	F	1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 🛣					Hican, etc.)		Black, White	etc.		
21215-0036	al", o	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1⊡Yes 2⊠XNo	Specify:		S	pecify: As	ian		
9-0	2 hou	Completed	15. Decedent's Ed (Specify only highest gra	ducation		16a. Dece	dent's Usual Occup	ation	kina	16b. Kind	of Business/li	ndustry		
218	hin 7 e.	ldu	Elementary/Secondary (0-12)	College (1-4or 5	5+)		kind of work done DO NOT use retired		9	4				
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yla	should be f and Mental I s marked of numatic eve	ျ	"Unknown" Tran				-	Lam '		O:	04-4- 7	in Ondo)		
lar	2 sho and ris me		19a. Informant's Name/Relationship (ng Address (Street							
	ss 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If then 27 is marked other than "natural", or items 23a or 28a-f show if them traumatic event, the Medical Eventime mast be notified at a other traumatic event, the Medical Eventime mast be notified.		Trung Thanh Tran 20a, Method of Disposition	(Son)	20h Pl		Knolls P				tion - City or T			
Baltimore,	Pages hent of hent; if ite		1 ☐ Burial 2 🛣 Cremation 3 🗆			-	osition (Name of matory or other place	2	Date 12 009					
ŧΪπ	t. Pa rtmer rtant njury		4 □ Donation 5 □ Other (Special		Met		itan Crem 2. Name and Addre	latory			indria,	VA.		
Bal	permit. Pages Department of Important: If it any injury or o		10 East Deer Park Drive Gaithersburg											
			22a Part 1 Enter the disease of com	polications that cause	d the death						.sburg,	Approximate		
			23a. Part 1. Enter the disease, of com- shock, of heart failure. List only Immediate Cause (Final	one cause on each li	ine.			20	COAST			Interval Between Onset and Death		
21	Physician /Medical		disease or condition resulting in death)				Y ARTO	sty pr	SEASE					
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al F	Th ate pag								1 □Yes	2 P No	1 □Yes	2 No		
Vit	Physician: this certific al director,	Be	25. Was case referred to medical examiner?	Hospital:		3	Oti	26. Place of Dea			T011			
of		음	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpat		28b. Time	ent 3 LI DOA	4 L Nursing F	lome 5 ☐ Res 28d. Describe			city)		
L O	tending F Jeath. tor: After the funera	흲	1 Accident 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay, Year)	Injury	of 28c. Inju Wo M 1 E	rḱ?]Yes 2.∐No						
Division of	Atten deat ctor: y the	fica	3 Suicide 6 Could not I	28e, Place of In	ا njury - At họ	me, farm, st	reet, factory, office		28f. Location	(Street and	Number or Ru	ıral Route Number,		
Ο̈́	after Dire d in b	Certification: To	4 Homicide	building, e	etc." (Specif)	/)			City or 10	òwn, State)				
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	calC	29a. Certifier 1 Certifying P	Physician: To the besuminer: On the basis	t of my kno of examina	wledge, dea tion and/or i	th occurred at the t	time, date and place opinion, death occ	e, and due to th urred at the time	e cause(s) a e, date and p	and manner a	s stated. to the cause(s)		
	the H nin 24 the F nplet	Medical	one)	and manner s	stated.			se number			signed (Mont			
_	Not To Con Con	-	29b. Signature and title of certifier	Proc	Van			057/2	. 4		1810			
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			30. Name and address of person who					cvilla M	D. 2085	0				
	-01	ata.	Truong Bao M.D. 31. Date filed (Month, Day, Year)	20 Regis	trar's Signa	ture		VATITE' I	۷. ۲۵۵۶	J				
	St Regist	ate rar	FFR 11 200		1	bas	Kad.							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 6, 2009 200 Year **Physician** James Dewey Thompson, Jr. 7:45 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County 48 North Houcksville Road Hampstead If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 3, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours 1 XM 2 ☐ F Months Aug. 78 213-26-9443 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modeal Examinar must be multified at Carroll County Maryland Hampstead 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hyglene.
Int: If item 27 Is marked other than "natural", or items 23a or: 48 North Houcksville Road 21074 United States Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Xyes 2 □ No 1948—
If Yes, Give
Year or Dates: 1954 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo white Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Etementary/Secondary (0-12) manufacture draftsman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Dewey Thompson, Sr. Eloise Lynch ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 48 North Moucksville Road Hampstead, Maryland 21074 Margarete Thompson - wife other 1 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hampstead Cemetery 20c. Location - City or Town, State Feb. 10, 20a. Method of Disposition Department of H Important: If ite any injury or of once. 1 Burial 2 □ Cremation 3 □ Removal from State Hampstead, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens Eline Funeral Home Hampstead, Maryland 21074 M01072 934 South Main Street 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on eight line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed physician and the burlal-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Certification: To Be Completed by 1 Tes 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 sl autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director. 26. Place of Death (Check on one) 25. Was case referred to medical examiner' Other: 4 \(\sum_{\text{Nursing Home}}\) ☐ Residence 6 ☐ Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 Pending 1 Tyes within 24 hours a er death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determi 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi ٥ 12 HYA

State Registrar

DHMH 17 Rev 1/2001

South Costee Street Westhinster, MS 21157

ompleted cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2009 2.550 M 02 MONTEON TRUSTY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CENTERVILLE QUEEN ANNE'S CORSICA HILLS If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1€M 2□ F Yrs. 219.80.9312 MD Director 10 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "neturel", or iteme 23e or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Chestertown Director KENT WD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7485 21620 USA TOPIAR AUE Funeral death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 To If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or iten any njury or other treumatic event, the Medical Exercitiest 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: DIACK Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FEREMANS Drothers 1200 DRICK I AYER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Blandustta Wilson LEON TEUSTY 19b. Mailing Address (Street and Number or Reval Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PAMELA DROWN-QUIT 20b. Place of Disposition (Name of cametery, crematory or other place)

20c. Location 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Anes United Methodist 2/14/2009 Chesteelown, mo 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility Kenneth WALLY Tuneral SERVICE 21. Signature of Funeral Service Licensee (WOOD 26) BIJ WEST STREET ANNAPOLIS, Macyland 21401 23a. Part1/Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** monutes /Medical Due to (or as a copsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine ete hes been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificete hes autopsy performed? Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation Natural within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. (Check only one) To the ! 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Teddemans Lane, Easton, 31. Date filed (Month, 32. Regi rar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 4 0460 Februar Harold Dean Tackett 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Union Hospital Elkton 8. Date of Birth (Month, Day, Year)
July 13, 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. Days Hours 1 XM 2 □ F Months 64 Yrs. 1944 Maryland Director 215-42-5895 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinating that is not the formal or any injury or other traumatic event, the Modical Examinating that is a possible of the modical Examination or other traumatic event. 1 ☐ Yes 2X No Directo Maryland Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 92 Mountain Rd. 21911 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: White δ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Miner Coal Mining 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ Grady Tackett Virginia Younce 19b. Mailing Address (Street and Number or Rural Route Number; City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeanne Dickens/Daughter 1540 Slate Hill Rd., Drumore, PA 17518 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 02-18-2009 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, Maryland 22. Name and Address of Facility
R.T. Foard Funeral Home, P.A. 21. Signature of Funeral Service Licensee 111 S. Queen St., Rising Sun, 21911 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial +09 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed physician are the burial-t Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year signed by the a d be detached for 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown s been s should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an cate has I page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 🗌 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number P0053309 - il 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Total M. Tongson, Union Hospite Elkton 2192 M. Tongson MD Union Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Trimmer Jean 2009 charmy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSUM REGIONAL MEDICAL CENTU NICOMICO SALISBUM If Under 1 Year | If Under 24 Mrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours 217-28-4572 Director 12/12/1931 Maryland Usual Residence of Decedent 10h County 10c. City. Town or Location 10a State 10d. Inside City Limits show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Director Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 139 Village Oak Drive 21804 USA 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: à Specify. 3 X Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than any Injury or other traumatic event the mans Injury or other traumatic event the mans Injury or other traumatic event the mans Injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lloyd Hosier Edna Adkins 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Marshall/niece 101 Beagle Ct., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/11/09 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furferal Service Licen Professional Association Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatu Physician Liver Cancer /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Lines to deliving Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death asn 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 | I Inknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page 2 No 2 (No 1 Yes 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day, Year) 27. Manner of Dea To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28c, Injury at Work? After t Certification: 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 029105 6 mx ss of person who completed cause of death (Item 23a) (Type, Print) 100£ Carroll St. Salisbury MD PRMC DR. C. Huddleston 31. Date filed (Month, Day. Registrar's Signat State Registrar

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	for State Registrar	State of Maryland	/ Department of I			ene 3. No.2 () () 9	06092
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			Decedent's Name (First, Middle, Last)							2. Date of Dea	ath Day	Year	3. Time of Death	
(-1)	Physicia /Medic		Eileen C. Turner							Februa	ry	10 200		
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S,	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	by P	Part II. Other significant conditions co	ntributing to death	but not result	ing in the u	nderlying cause gi	ven in Part I	l.	23e. Did to	obacco u	se contribute t	o the cause of death?	
Division of Vital Records,	requir	ted								1 🗆 🕆	Yes 2]No 3∏F	robably 4 donknown	
Rec	ne law has b	Completed								24a. Was autor perfo	an osy rmed? /	24b. Were a prior to death?	utopsy findings available completion of cause of	
ta	sm: Th tifficate or, pag		25. Was case referred to medical					26 Place	e of Dooth	1 ☐ Yes	2 1 NO		s 2 DNO	
f Vi	rysick lis cer direct	o Be	examiner?	łospital: 1 ☐ Inpa	itient 2 ☐ E	R/Outpatie	nt 3 DOA Ot	hor:		me 5 ☐ Resi		3 ☐ Other (Sp	ecify)	
0 10	Ing Pt After th uneral	C:uo	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Ir (Month, I	njury 2 Day, Year)	8b. Time o Injury	Wo			28d. Describe I	how injury	y occurred		
isio	death ctor: /	ficati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of I	niury - At hom	ie, farm, str	M 1 C]Yes 2 []		28f. Location /	Street an	d Number or F	Rural Route Number,	
Ωį	al or A s after I Dire	Certification: To	4 Homicide determined	building,	etc. (Specify)					City or To	vn, State)	ara. riegie rarize,	
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ner: On the basis	of examination									
	ithin 2 the P	Medical	29b. Signature and title of certifier	and manner	stated.		29c. Licen	se number			29d. Dat	te signed (Mon	th, Day, Year)	
	FSFÖ	3	V/Malante	MIT		UD	カ	6/15			2	19/00	Ŋ	
	205	1	30. Name and address of person who co	ompleted cause o	f death (Item 2	23a) (Type,	Print)	- 1			/		WY MOZIROL,	
	BA5		31. Date filed (Month. Day Year)	4P/-)	6/4	<i>B</i>	EASTER	N S	SHORE	1EDR	, 5,	4-LISB	WY MDZI ROLI	
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 2 200	19 Serve	strar's Signatu	. 400	uks							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day February 14, 2009 4:41 pM Joseph Charles Titus 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) St. Mary's Leonardtown St. Mary's Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex Months Days Hours 1 M 2 □ F Yrs. 2, 1951 58 Jan. Maryland 214-58-0201 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No St. Mary's Ridge Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20680 49697 Bayne Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) assistant Chief of ire Prevention Elementary/Secondary (0-12) College (1-4or 5+) Naval Sir Station 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ridge11 Titus Cecilia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances B. Titus/Spouse P.O. Box 155, St. Inigoes, Maryland 20684 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1x Burial 2 □ Cremation 3 □ Removal from State St. James Cemetery 2/19/2009 Lexington Park, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 Edward Minerield, Jr. M00052 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) denal Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 √Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

Physician /Medical Examiner Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a, State

Directo

Funeral

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Completed

Be

Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" any injury or other traumatic events.

burial-trai attending physician for use as the buris ed by the a detached f Hospital or Attending Physician: '24 hours after death, Funeral Director: After this certificat in by the funeral director,

Charles

Examine Physician/Medical Completed by Be 2 Medical Certification: To the Hospital within 24 hours a To the Funeral C completely filled in illed

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death

29a. Certifier

(Check only one)

5 Pending investigation 1 Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 - Homicide

f certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

1 Inpatient

(Month, Day Year)

28a. Date of Injury

29c. License number 10067399

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

Theodora MD YAA

31. Date filed (Month, Day, Year) FEB 18 2009

St. Mary's Hospital P.O. Box 527 Leonardtown md 20650 32. Registrar's Signature

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

M

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Feb 21, 2009 Physician 10:20pm VanMeter Virginia Gladys /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Frostburg WMHS--Frostburg Nursing & Rehab If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Sep 3, Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days Hours Min. 1 □ M 2 □ ₹ 214-07-2293 94 1914 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the "Mutical Exercises Total be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 □ No Frostburg MD Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 48 Tarn Terrace 21532 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐**X**io 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ NX Specify white 3 XWidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Board of Education secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lloyd M. Bittinger Carrie Bittinger 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a, Informant's Name/Relationship (Type, Print) 4209 Kensington Road MD 21229 Richard VanMeter Baltimore son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Kurial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial Park 2/28/2009 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Fervice Ucensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part 1. Inter the distrase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease of condition resulting in death) Athorosclerotic **Physician** 2 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director: name 2 should he director. Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23d. Date of delivery ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 □Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: nours after death.

neral Director: After this or 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier worsock Shr 00055325 Feb 22, 2009

DHMH 17 Rev 1/2001

State Registrar WONSOCK

strar's Signature

925 Bishop Walsh Rd Cumberland MD21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

FEB 11 2009 Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15424

MD

2. Registrar's Signature

ORIGINAL

29c. License number

9901 Medical Center Drive, Rockville, MD 20850

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1 Decedent's Name (First Middle Last 2. Date of Death 3. Time of Death 200^{Year} Day **Physician** JAN. 31, GERALDINE **EMMA** WATERS 2140 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital PRINCE GEORGES Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🙀 Sept. 19,1911 Maryland 97 Director 215-26-2169 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County , and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Exprimer must be ristified at Yes 2 □ No MD Forestville Director Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 20747 U.S.A. Ida Court 3803 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ No If Yes, Give Specify à Specify Black 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Frederick Co. College (1-4or 5+) Elementary/Secondary (0-12) School Teacher Public Schools yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If item 27 Is marked oth any injury or other traumatic event Be John William Bruner ပ္ Jeannette Celestia Bruner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita N. Moore (Daughter) 3803 Ida Court, Forestville, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Wayman AME Church Cem 2/13/09 Frederick, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signatur Funeral Service Lice 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of and burial-trar law requires that the death certificate be exec Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: for use yes, outcome of pregnancy

Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. the 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 🏡 Inpatient 1 ☐ Yes 2 XNo 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Matural 5 Pending 1 ☐ Yes 2 ☐ No spital or Attendi lours after death. neral Director: A death. investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D064289 09 Volle Kar 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 Surrats Rd, Clinton, MD Varsha Vanikar, M.D.31. Date filed (Month Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day February 09 2009 1:00₽ м Wilma Arlene Wagner 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Carroll 1921 Fawn Way Finksburg If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Aug 12 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1 ☐ M 2 🔀 F Aug 86 302-28-5804 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 1 ☐ Yes 2 No Carroll Finksburg MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21048 1921 Fawn Way 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify. 3X Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katherine Bowser Wilbur Nve 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Uhler/daughter 1921 Fawn Way Finksburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 02/12 2009 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Finksburg, MD 4 Donation 5 XOther (Specify) Entombrent Evergreen Memorial Gardens 21. Signature Prince After Franky Home and Chapel, P.A. of Funeral Service Westminster, MD 21157 412 Washington Road 23a. Pan. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Respircute Immediate Cause (Final many disease or condition resulting in death) Due to (r as a consequence of): a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence.) Due to (or as a consequence of) f yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 214No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No Was an performed. res 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No 1 🗌 Yes

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

r than "natural", or Items 23a or the Medical Examiner must be r

72 hours after

Hygiene.

d 2 should be filed w. the and Mental Hygier 7 is marked other the

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any Injury or other traumatic event, I

Saltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Examiner burial-tran attending physician for use as the burial ed by the a been signed by should be detacl has certificate

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

director, this

Physician/Medical þ Completed Be ၉ To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is Certification: Medical

23b. Was decedent pregnant

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

1 Natural

Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of centifier NILAE U

5 ☐ Pending investigation

6 ☐ Could not be

determined

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

912 washington NILAR

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

MJI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 06099 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 1:15 PM 2009 Februmey Nancy Kay Wisherd 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Washington County Hagerstown Washington County Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) 5. Social Security Number 1 □ M 2 🛛 F Months Days Hours 214-28-5680 77 June 18,1931 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 1 □ Yes 2 No Maryland Washington County Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21783 U.S.A. 12010 Holiday Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □ XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Personal Residence Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Mildah McFerren Nugent Ralph G. Nugent 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwin L. Wisherd-husband 12010 Holiday Circle Smithsburg, MD 21783 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-14-2009 Hagerstown, Maryland Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FREAROVACCUL disease or condition resulting in death) Due to (or as a consequence of) ATHOLOSCEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown INFECTION CALCULI HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No performed 1 ☐ Yes cal 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

Examiner

Funeral

Director

or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

aith and Mental Hygie

27 Is marked other the traumatic event.

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once.

death

filed within 72 hours after

Saltimore, Maryland 21215-0036

Director

by Funeral

Completed

/Medical

Examine Physician/Medical Completed by Be

Medical

physician and s the burial-trans attending p for use as t certificate has been signed by the rector, page 2 should be detached within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Certification: To

Division of Vital Records, P.O. Box 68760,

			'	
25.	Was ças	erred	to m	edic
	examine	No		

29a. Certifier

(Check only one)

1 Natural 2 □ Accident 5 Pending investigation 3 Suicide

6 ☐ Could not be 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) FEBRUARY 11, 2009

HAGERSTOWN,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUITE MD ORD IIIO MED

and manner stated.

State Registrar

Year) Day, **FEB 17** 32. Registrar's Signature

54-4

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #23 Per PHYS 2/11/09 CCHH DB Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2009 6, 3:00 Fannie Massie Weston February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles Waldorf Genesis Elder Care Months Days Hours Min. 8. Date of Birth (Month, Day, Year)

June 21, 1900 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months 1 □ M 2 🔀 F 108 Virginia Yrs 231-03-9705 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-i shov any Injury or other traumatic event, If a Medical Exp.: in at a rout by colling an 1 Yes 2 □ No Director Maryland Charles Indian Head 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20640 U.S.A. 114 Circle Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White ð 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Mixologist Tavern 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Betty Withers Newton P. Massie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 155, Bryans Road, Md. James A. Weston Son 20616 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Jonesboro Cemetery Feb. 12,2009 Roseland, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Williams Funeral Home, P.A. M00668 Vas 4270 Hawthorne Rd., Indian Head, Md. 20640 isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the shock, or hear Immediate Cause Final disease or condition resulting in death) Sen Physician old /Medical Due to (or as a consequence of): Examiner MACULAR DEGENERATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed ARTHRITIS and burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical OSTEOPOROSIS the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.O. 9 Unknow signed by t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) è 24 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: or Attending Patter death. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 2/10/09 POPYOUT MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2070 Old Line Center Suite 100 Walderf, Mo 20402 31. Date filed (Month, Day, Year) FEB 1 1 2009 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1:55 Am **Physician** FEBRUARY 10 2009 WILLIAM F. WOLFE, JR /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 🛣 M 2 🗆 F WASHINGTON, D.C. 82 MARCH 24, 1927 579-40-2081 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show ither traumatic event, If a Modical Examinar must be notified at 1 ☐ Yes 2 No Director QUEENSTOWN QUEEN ANNE'S MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 219 BRYANTOWN LANDING 21658 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∑Yes 2 □ No If Yes, Give Year or Dates:1945—1947 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 📉 No Specify. à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER INSURANCE 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FLORENCE MURPHY WILLIAM F. WOLFE, SR ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 219 BRYANTOWN LANDING, QUEENSTOWN, MARYLAND 21658 permit. Pages 1 and:
Department of Health
Important: If Item 27
any Injury or other tr.
once. PHYLLIS WOLFE/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition FEBRUARY 13 CHRIST EPISCOPAL 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 CHAPTICO, MARYLAND CHURCH CEMETERY 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee M 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ **(**No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Injury 5 Pending investigation n 24 hours after death.

le Funeral Director; Aft
bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 803 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 12 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 10:00 PM Feb 11, Rosella Wright 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Charles Waldorf Health Care Center/Genesis Waldorf If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 ☐ M 2 🔀 F 83 3/17/1925 Illinois 430-30-0852 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 No Prince George's Riverdale 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20737 U.S.A. 4706 Queensbury Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify White 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Barto Charley Pulliam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13010 Hickory Avenue, Waldorf, MD 20601 Darla Fields / granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery | 2/18/2008 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funery Service Licensee 4739 Baltimore Ave. ennth Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) tailuve Chromic Kenal yech Due to (or as a consequence of): Engle rive if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Stude Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

other traumatic event, the Medical

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Pages 1 nent of F ant: If ite

Department of Important: If any Injury or once.

Director

Funeral

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Completed

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should be filed within 72 hours after death with the Maryland and Mental Hygiene. smarked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

/Medical

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law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
leted by Physician/Medical Examine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 🏄 🗖 No 9 ☐ Unknown
eted by Pł	Part II. Other significant cond

29b. Signature and title of certifie

-	Part II. Other significant conditions of	contributing to death but not res	uiting in the unde	riying ca	ause given in Part I.	23e. Did tobacco di	se continuate to the cause of death.	
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complete						24a. Was an autopsy performed? 1 Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
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0.0	examiner? 1 ☐ Yes 2 ☐ \ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 DO	Other: 4 Nursing H	ome 5 Residence 6	G □Other (Specify)	
ation: T	27. Manner of Death 1.	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred	
Certificati	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, street	, factory	, office	28f. Location (Street and City or Town, State,	d Number or Rural Route Number,)	
calC		nysician: To the best of my knominer: On the basis of examina					and manner as stated. place, and due to the cause(s)	

29c. License number

1042049

upper Marlboro MD

29d. Date signed (Month, Day, Year)

February 12, 2009

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State Registrar

HAMPALOUX 6. 31- Date-filed (Month, Day,

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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To the Funeral D

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			Registrar Decedent's Name (First, Middle, Last)	st)		- Innounce of E		2. Date of Dear	th	3. Time of Death	
	ysicia Iedica		Gilbert J	. Т.	Williams			Month Februar	y 6, 20	09 12:53	1
₹.,	amine		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County o	_	
:			Prince George's 5. Social Security Number 6. S	Hospital C	Center (In yrs. last birthday)	Cheve If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	e George s 9. Birthplace (State or Foreig Country)	gn
Fun Dire				DVM 2DF	8 Yrs.	Months Days	Hours Min.	(Month, Day March 1		Washington, I	
D		-	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	cation				10d. Inside City Limits	
laryla shov	te pa		Maryland Prince		•	Marlboro				1 TYes 2 □ No	0
the N	notifi	rect	10e. Street and Number		11	10f. Zip Code		-	10g. Citizen of W		\neg
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Id yidili Zizizioooo Sebould be filed within 72 hours after death with the Maryland and Mental Hygiene. amarked other than "natural", or items 23a or 28a-f show	or other traumatic event, the Medical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race Black	e - American Indian, k, White, etc. African	
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2 shour and he ls ma	auma	T	19a. Informant's Name/Relationship (ı	ng Address (Street					
and and the setting the settin	ther tr	7	Gilbert O. Willi 20a. Method of Disposition	ams - Fathe		Lakeston		pper Mar		MD ZU774 City or Town, State	-
parmit. Pages 1 and 2 Department of Health 8	yoro		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4☐ Donation 5 ☐ Other (Special		20b. Place of Dispo	oln Cemet	1	12 2000) Brants	wood MD	
Dallillor permit. Pages Department of	'Injur	1	21. Squarre of Furreral Service Lice			2. Name and Addre				Home, Inc.	
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Physi- /Med			Immediate Cause (Final disease or condition resulting in death)	a	rere	10/4	ein -	Lnj	WY		_
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&/oU, cate be executed physician and	s the burial-transit	dical E	l l	Due 10 (01 de d	0011004401100 0.7.	Aplo	And Al	to thoo	55927		
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Ords, P.O. BOX or requires that the death certification is the attending to	hed fo	hysician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death 5	Other (specify) _					
that the year	detac	Δ.	Part II. Other significant conditions	contributing to death bu	t not resulting in the u	underlying cause giv	ven in Part I.	23e. Did to	obacco use contr	ribute to the cause of death?	
rds quires	nld be	ed by			·			101	Yes 2⊡No	3 Probably 4 Unknow	٧n
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The law	page	Com						1 □ Yes	2 □ √√0 1	death? 1 □Yes 2 □ No	
OT VITAL Physician: T	rector	Be	25. Was case referred to medical examiner?	Hospital:	nt 2 ☐ ER/Outpatie	Ott	hor:	ath <i>(Check only o</i>	<i>one)</i> dence 6 □Oth	per (Specify)	_
Phys	eral di	٦: ا	1 Yes 2 No 27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time			28d. Describe	how injury occurr	red Driver of	_
ending ath.	he fun	atio	1 □ Natural 5 □ Pending 2 ☑ Accident investigation	on February	6,2004 100	3 M 1□	Yes 2 No		ost con		
DIVISION I or Attending after death.	in by t	Certification:	3 Suicide 6 Could not l 4 Homicide determined		ry - At home, farm, st c. (Specify)	treet, factory, office		28f. Location (Street and Numb wn, State)	Driftwood	,24
Spital ours a	filled		29a. Certifler 1 ☐ CertifyIng F	Physician: To the best of	of my knowledge, dea	ath occurred at the t	time, date and plac	e, and due to the	cause(s) and ma	anner as stated.	TU
DIVISION To the Hospital or Attending within 24 hours after death.	completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical Exa	aminer: On the basis of and manner sta	examination and/or i	investigation, in my	opinion, death occ	urred at the time,		and due to the cause(s)	
5	COM	Σ	29b. Signature and title of certifier			29c. Licen	se number		0	ed (Month, Day, Year)	
	7		lwy/	V9	onth (Itom 22a) /Fire	Definit)	0386	ℓ	d 10	0-09	_
R	5		30. Name and address of berton with Carnell Cooper,		eath (Item 23a) (Type . Hospital		everlv.	MD 20785			
	Sta	ate	31. Date filed (Month, Day, Year)	32. Redistra	ar's fignatur		==1,,				
R	egistr	rar	FEB 13 2009 A	weren the	7						

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

P.O.

Fisehatsion Mehari, MD 9901 Medical Center Dr Rockville, MD 20850

2. Registrar's Signature

he Hospital or Attending Physician: Ti in 24 hours after death. he Funeral Director: After this certifica pletely filled in by the funeral director, pa To the

> State Registrar

29b. Signature and title of certifier

Pamela E. Southall, MD

ruthell

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

February 19, 2009

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** MMYMW 12:10a 9, 2009 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Fairhaven Sykesville Carroll 1 Year 5. Social Security Number 6 Sex If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🗷 F 177-12-6057 89 Jun 11, Director 1919 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other then "naturel", or items 23a or 28a-f show any Injury or other traumatic event, the "Modital Evanther must be notified at once. 10a State 10b Counts 10c. City, Town or Location 10d Inside City Limits Director Maryland Carroll 1 XYes 2 No Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 3rd Avenue 21784 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14 Bace - American Indian. 1 □Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. Specify: White 3 ₩ Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Library Science Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Philip Vooz Bertha Krause ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew S. Zimmerman, son 3801 Salem Bottom Road, Westminster, MD 21157 Baltimore. 20b. Place of Disposition (Name of Somethy crematory or other place)
Carroll Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State 2/10/2009 Winfield, MD 4 □ Donation 5 □ Other (Specify) ture of Funeral Service Licensee 22. Name and Address of Facility Myers-Durb raw Funeral Home 91 Willis Street, Westminster, MD 21157 Jan 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme late Cause (Final disease or condition resulting in death) **Physician** Lews /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. e Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or inju-that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No of Vital 1 ☐ Yes 1 ☐ Yes

filled in by the funeral director, page 2 should be Be

To the I within 2. WIL

Division

was autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Ma r of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

9,7009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

295 SP Nev 32. Registrar's Signature

State Registrar

Medical

29a Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

onn (

FEB 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Mary		rtificate of L			2009	06107	
	Div	_	1. Decedent's Name (First, Middle, L	ast)				2. Date of Death Month	Day Year	3. Time of Death	
	Physician /Medical			ellington	Ambrose	4b. City, Town, or		FEB 2	2 2009 4c. County of Death	1131	
	Examine	r '	la. Facility Name (If not institution, g	ive street and number) ECIALTY Ho	ISPITAL.	BALTIN			40. County of Beas		
41-14				Sex 7. Age (Ir	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birth	place (State or Foreign intry)	
	Funeral Director		235-36-4005	1 ◯X M 2□ F	81 Yrs.	Months Days	Hours Min.	March 1	1,1927 WV		
	pr ,	- 1	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits	
	show show		MD 10a. State 10b. County Char		LaPlat					1 □ Yes 2 No	
	the N	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?	
	3a or		535 Clarks Run	Road		2064			United St		
	ems 2	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spec in, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White		
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at		1 ☐ Never Married 2 ⚠ Married 3 ☐ Widowed 4 ☐ Divorced		WII	1 □ Yes 2 🛣 No	Specify:		Specify: W	nite	
4165 215-0036	tural	Completed by	15. Decedent's (Specify only highest		16a Dece	edent's Usual Occup	ation	1	6b. Kind of Business/l	ndustry	
111 215	hin 72 e. an "na Medli	plet	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of working Supervise	I .	Metro DC		
22	ed wit ygien yer tha t, the	Co	12		2	cheduring	18. Mother's Name				
l) and	be fill hall H	Be	17. Father's Name (First, Middle, La James Burr Ambr				Jennie		·		
SS IN	should nd Me mark maric	ဥ	19a. Informant's Name/Relationship		19b. Mail	ing Address (Street	and Number or Rura	l Route Number,	City or Town, State, 2	Zip Code)	
\$ E	nd 2 salth ar		Gertrude Ambros						, MD 20646		
MOR. Manore, Ma	es 1 a of Her		20a. Method of Disposition XXBurial 2 □ Cremation	Removal from State		osition (Name of ematory or other place	ce)		20c. Location - City or		
1/2 imc	Pag ment ant: I		4 ☐ Donation 5 ☐ Other (Spe	cify)	MSVC-Che				Cheltenham,		
AMBRUSご Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Įij	21. Signature of Fundral Service	censee		5635 Washi	naton Ave	ymona ri nue. La	uneral Serv Plata, MD	20646	
- 1	FD 7 0 0		23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caused th	e death. Do not e	nter the mode of dyir	ng, such as cardiac o	or respiratory arre	est,	Approximate Interval Between	
	Physician		shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on each lift	0600	Star	Fail	ار و		Onset and Death	
	/Medical		resulting in death)	Due to (or as a c	consequence of):	0					
	Examiner	_	Sequentially list conditions,	b	Consequence of):	58PS1	<u> </u>				
lot	ted	nine	Sequentially list conditions, and a second conditions cause. Enter Underlying Cause (Disease or injury that initiated events	Buc to for as a c	onougaonee en						
(,	execuna and ial-tra	Examiner	resulting in death) Last	Due to (or as a c	consequence of):						
68760,	tificate be executed g physician and as the burial-transit	edical	'	d							
	ertifica ling ph e as t	Med	IF FEMALE:	23c. If yes, outcome pf	pregnancy			-	23d. Date of de	livery	
Вох	w requires that the death certiff been signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at til	Fetal death	B ☐Ectopic pregnanc □ Other (specify) _	у		Month	Day Year	
	the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown							
G.	ss that gned t		Part II. Other significant conditio	ns contributing to death but	not resulting in the	underlying cause gi	ven in Part I.		bacco use contribute t es 2 □ No 3 □ P	/	
ord	requir	ted	H Tre	-4022	~						
ec ec	has by	Completed by	C. 24		\ (24a. Was an autopsy performe			med? prior to death?		
								No 1 ☐Yes 2 No			
≅	ysicia s certi	To Be	examiner?	Hospital: 1 Impatient	t 2 ☐ ER/Outpat	ient 3□ DOA Ot	t		ence 6 □Other (Sp	ecify)	
ō	ing Phys n. After this funeral dir		27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time	y Wo	ork?	28d. Describe h	ow injury occurred		
Siol	tendile eath. tor: A the fu	catic	2 Accident investig 3 Suicide 6 Could n	ation	y - At home farm	M 1 1 street, factory, office]Yes 2⊿No	28f. Location (S	treet and Number or F	Rural Route Number,	
ivi	or At after d Direc	ertifi	4 ☐ Homicide determi	building, etc.	(Specify)	andon, ladiony, amou		City or Tow	n, State)		
_	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	(Check only 2 Medical	g Physician: To the best of Examiner: On the basis of	examination and/o	eath occurred at the rinvestigation, in my	time, date and place, opinion, death occur	, and due to the or	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)	
	the Frin 24	Medi	one) 29b. Signature and title of certifier	and manner state	ed.	29c. Licer	nse number		29d. Date signed (Mor	nth, Day, Year)	
	7 × 5 0		1/	(0000	∞	D	4383	0	2/24	109.	
	7+1		30. Name and address of person	who completed cause of de	ath (Item 23a) (Typ	pe, Print)	21	- <1	13.11	21230	
. 16		ate	31. Date filed (Month, Day, Year)	32 Aegistra	r's Signature	01 0 (horse	S 24.	1) - ITION	11/14.	
	Regis	77.7	FER 27	2009 Sekun	r's Signature	barker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician Loretta E. Apicella 9:55a February 26,2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Manor Care Rossville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🔀 F 216-30-2472 74 7-1-1934 Baltimore, MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Novical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Perry Hall Directo MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9639 Gerst Road 21128 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No Specify: White þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home maker In own home 12th Jih and Mental Hv. 7 is mark. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Cieslak Elsie Kamasinska 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) und 2 Pages 1 and 2 9639 Gerst Rd., Perry Hall, MD 21128 Lisa Miller Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/2/2009 |Baltimore, Maryland Department or Important: If any injury or Stanislaus 22. Name and Address of Facility Joseph N. Zannino 21. Signature of Fineral Service Lucin see 263 S. Conkling St.Baltimore, MD 21224 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part r. Enter the dis shock, or heart fail. Immediate Cause (Final Physician Year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a year of the cause of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burlal-transit and Due to (or as a consequence of) Box 68760 physician Physician/Medical IF FEMALE: use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year jo Month Day 5 ☐ Other (specify) Ö detached the 9 Unknown 9 ☐ Unknown s been signed by t should be detach ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has 2 No 1 □Yes 2 DNo certificate 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 IIII No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D5105/ february 26,7009 Ligon Rd, Ellicott City, MD 21042 and address of person who completed cause of death (Item 23a) (Type, Print) 14291 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

	FOR	epartment of Health and Monager Certificate of Death	ental Hyglene 2009 0610
Physician /Medical	1. Decedent's Name (First, Middle, Last) Erna Caroline Antkowiak		2. Date of Death Month Day Pear BRUARY 24, 2009 07:15
Examiner	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Cente		AND AND OF THE REE COST Very
Funeral Director	5. Social Security Number 6. Sex 1 M 2 1 F 7. Age (In yrs. last birt) 212-34-8757 Usual Residence of Decedent	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 03/08/1914 9. Birthplace (State or Fore Country)
f show	10a. State 10b. County 10c. City, Town		10d. Inside City Lim 1 ☐ Yes 2 🔯 I
a or 28a-f st Lbe notified I Director	MD Baltimore Parky 10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
e. "natural", or items 23a or 28a-f show Mudical Evaniner must be notified at npleted by Funeral Director	8415 Numley Dr. Apt. D 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	21234 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	Specify: White
yglene."naturs t, In Medical F	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired) OME Maker	Own Home
Be even	17. Father's Name (First, Middle, Last) Richard Arndt	18. Mother's Name Adelle	(First, Middle, Maiden Surname) Habick
Department or results when a limportant: If item 27 is marked any injury or other traumatic evonce.	19a. Informant's Name/Relationship (Type. Print) Karen Scherr/Granddaughter 20h Place of	013 Cockeys Mill Rd.	Reisterstown, MD 21136 ate 20c. Location - City or Town, State
physician and majorithe burial-transit united and united and united and united united and united uni	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions of	RDIAL INFARCTION on:	r respiratory arrest, Interval Between Onset and Death HOURS
d by the attending petached for use as Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)	23d. Date of delivery Month Day Year
hould be d	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unkr 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause death?
ector Be	27. Manuer of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day, Year) 28b.		1 ☐ Yes 2 XNo 1 ☐ Yes 2 XNo
ours after death. eral Director: After this c filled in by the funeral dire.	2 Accident 3 Suicide 4 Homicide Could not be determined See. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State) and due to the cause(s) and manner as stated.
To the Funeral Direction of the Completely filled in the Medical Certi	(Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier	d/or investigation, in my opinion, death occurr	ed at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
> = 0	30. Name and address of person who completed cause of death (Item 23a)	D25886 (Type, Print)	February -26-
State Registrar	LILIA CERALLOS, M. D. 76.01 Constitution of the filed (Month, Day, Year) is 2. Registrar's Signature		N, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of W	-	Certificate of			g. No. 2 0 C	09 06110
	Physicia	an	1. Decedent's Name (First, Middle	le, Last)	A			2. Date of Death Month		3. Time of Death
	/Medic		Clyde Brady					Februar		009 6:01 AM M
	Examin	er	4a. Facility Name (If not institutio	n, give street and number)		or Location of Deat	h	4c. County of	
			Anne Arunde 1 5. Social Security Number		nter ge (In yrs. last biri	Annapo.	Lis I If Under 24 Hrs	8. Date of Birth	Anne A	rundel 9. Birthplace (State or Foreign
Н	Funeral Director		212-52-4267	1 ∑ M 2□F		Yrs. Months Days	Hours Min.		1946 W	Vashington DC
	land ow		Usual Residence of Decedent 10a. State 10b. County	/	10c. City, Town	n or Location				10d. Inside City Limits
	Mary a-f sh	tor	MD Anne	Arunde1	Ed	gewater				1 □ Yes 2 🙀 No
	or 28	Jire	10e. Street and Number		1	10f. Zip Code		10	g. Citizen of Wh	•
	23a ust b	ral	144 WAshington				21037		USA	
9	should be filed within 72 hours after death with the Maryland ind Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, its Modical Examinational be notified at	/ Funeral Director	11. Marital Status 1 X Never Married 2 Mar	If Yes Give	?	13. Was Decedent of If Yes, specify Cull		Specify Yes or No- to Rican, etc.)	Black,	- American Indian, White, etc. white
21215-0036	hours tural",	ed by	3 Widowed 4 Divorced	d Year or Dates: nt's Education		Decedent's Usual Occu		1	6b. Kind of Busin	
7	iin 72 n "nai	plet	(Specify only higher	est grade completed) College (1-4or		(Give kind of work done life. DO NOT use retire	during most of wo	rking	051 14114 01 54011	dik
212	d with /giene er tha	Completed	9	0	3+)	1abc	T-			
Maryland	be file ntal Hy ed oth event	Be	17. Father's Name (First, Middle,	, Last)		unk	18. Mother's Na	me (First, Middle, M	alden Surname)	un]
ır.	should nd Me marke	မ	19a. Informant's Name/Relations	ship (Type, Print)	19b	. Mailing Address (Stree	t and Number or R	ural Route Number,	City or Town, S	tate, Zip Code)
Z	alth al 27 Is		Frank Tolbert/		9:	31 Lower Pi	ndell Roa	ad Lothian	1, MD 2	.0711
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Medical Exaction at 15 or public of any Injury or other traumatic event, Its Medical Exaction and 15 or public of any Injury or other traumatic event, Its Medical Exaction and 15 or public of any Injury or other traumatic event, Its Medical Exaction and 15 or public of 15 or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other (5	3 ☐ Removal from State	cemeter	f Disposition (Name of ry, crematory or other pla	ace)	Date 2	0c. Location - Ci	ity or Town, State
Baltii	Departm Departm Importar any Injur		21. Signature if thereal Struce			State Ana			Baltimo:	re Street
ė			23a. Part 1. Enter the disease, o	or complications that cause	ed the death. Do	Baltimore not enter the mode of dy			est,	Approximate
8	Physician		shock, or beart failure. List Immediate Cause (Final	t only one cause on each	line.		the.			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or a	s a consequence	of):				COOP AGON
	Examiner	<u></u>	Sequentially list conditions,	b. Due to (or a	s a consequence	of):				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Bue to (or a	s a consequence	01).				
ó	tificate be executed ig physician and as the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or a	s a consequence	of):				
68760,	ate be	Aedical		d						
	E 5, a	/Mec	IF FEMALE:	23c. If yes, outcom	e of pregnancy				and Date	of delivery
P.O. Box	Physician: The law requires that the death ce this certificate has been signed by the attendiral director, page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth	2 ☐ Fetal death at time of death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	ncy		23d. Date Mont	
	s that t ned by e detac	by Ph	Part II. Other significant condit	ions contributing to death	but not resulting in	n the underlying cause g	iven in Part I.	23e. Did tob	acco use contrib	oute to the cause of death?
ğ	w require s been sig should b		Diabe	tes		?	•	1 ☐ Ye	s 2∐No 3	B□ Probably □ Unknown
Vital Records,	: The law r cate has be page 2 sh	Completed	Peno	treas v	as celle	an dura	we	24a. Was an autopsy perform 1 □ Yes 2	pri ned de	ere autopsy findings available ior to completion of cause of eath? □ Yes 2 □ No
/ita	ician: Th certificate ector, pag	Be	25. Was case referred to medica examiner?					ath (Check only one		
of <	Physician: this certific	မ	1 Yes 2 No			Jupatient 3 1 DOA		Home 5 Reside		<u> </u>
ou	ding Phy h. After thi funeral	tion:	27. Manner of Beath 1 Natural 5 ☐ Pendi	28a. Date of In ing (Month, E tigation	olay, Year) 285.	Time of lnjury M	uryat ork?]Yes 2 ∐No	28d. Describe how	м injury occurred	ş
Division	or Atten after deat Director:	Certification:	3 ☐ Suicide 6 ☐ Could		njury - At home, fa etc. (Specify)	arm, street, factory, office		28f. Location (Str City or Town		r or Rural Route Number,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Co		ing Physiclan: To the bes if Examiner: On the basis and manners	of examination ar					
	To the within To the comple	Mec	29b. Signature and title of certif	DM	جہ میا	29c. Licer	nse number	26	d. Dat signed ((Minth, Day, Year)
			30. Name and address of person	n who completed cause of	death (Item 23a)	(Type Print)			0111	107
			J MOCOT	2001 Wed	hoolph	swy A	ngosal	inno	214	01
	Sta Registi		31. Date filed (Month, Day, Year FFR 2 7 200	473	strar's lignature	and o	V			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2009 5:55 A PAUL BILGER, JR. February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore County GILCHRIST CENTER AT GBMC Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Min. 1**∑**M 2□ F Months Days Hours 78 Oct 12, 1930 Maryland 213**-**26-6113 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 1 ☐ Yes 2 🔽 No Maryland Baltimore County Lutherville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21093 1506 Pot Spring Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Lawn & Nursery Service Proprietor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marguerite Beatrice DuBrul Paul Bilger, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Wife) 1506 Pot Spring Road, Lutherville, Maryland 21093 Mrs. Elizabeth R. Bilger 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 4 Donation 5 Dother (Specify) New Cathedral Cemetery 2/28/2009 Baltimore, Maryland 21. Signature of Funciet Service Disease New Cathedral Cemetery 2/28/2009 Baltimore, Maryland 22. Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 212. Signature of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 212. Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland Approximate Shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Months

Month

Day

February 25 2009

Year

4 Unknown

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, The Medical Exprises must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760 ←

Physician

Examiner

Funeral

Director

/Medical

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9 Hospital or Attending Physician: The law requires that the death certificate be executed by the brours after death.
9 Funeral Director. After this certificate has been signed by the attending physician and eleip filled in by the funeral director, page 2 should be detached for use as the buriat-transit eleip.

Immediate Cause (Final disease or condition resulting in death) GASMIC ANCER Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed Be Certification: To Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

					,
				24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No
25. Was case referred to medical			26. Place of Dea	th (Check only one)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3 ☐ D	OOA Other: 4 Nursing H	ome 5 Residence 6	other (Specify) WSpul.
27. Manner of Death → Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 □Yes 2 □No	28d. Describe how injury	
3 ☐ Suicide 6 ☐ Could not be determined		home, farm, street, factor cify)	ry, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier (Check only one) 1 → Sertifying Property 2 → Medical Example 1	nysician: To the best of my ki miner: On the basis of exami and manner stated.	nowledge, death occurre nation and/or investigatio	d at the time, date and place on, in my opinion, death occu	e, and due to the cause(s) rred at the time, date and	and manner as stated. place, and due to the cause(s)

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To the I within 2.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month BAGROSKY 1055 PM RAYMUND WILLIAM 02 24 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARFORD UPPER CHESAPEAKE MEDICAL CENTER BELAIR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 6. Sex 1 M 2 F 9. Birthplace (State or Foreign 5 Social Security Number 213–42–3810 Hours 2/01/1943 Months Days Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2\No Harford County Jarettsville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21084 United States 3829 Belmont Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? TY Yes 2 No If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2 ☐XNo 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Disabled None 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ann Pannebaker Raymond Bagrosky, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret L. Bagrosky (Wife) 3829 Belmont Drive, Jarrettsville, Maryland 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 2/26/2009 Evans Funeral Chapel 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services — Bel Air
3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licenses for COM Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Levebral Interet 10 days resulting in death) Due to (or as a consequence of): Hyper lensoon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (*r as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Lung 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Corona autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner?

Physician /Medical Examiner

Physician

/Medical

Director

Completed

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Examiner

Funeral

Director

Show a or 28a-f show t be notified at

"natural", or Items 23a

permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical Ponce.

burial-trai neral director,

Examine Physician/Medical attending pt ed by the a Completed by has certificate Be ို Certification:

To the Hospital or Attendil within 24 hours after death.
To the Funeral Director: A completely filled in by the fu

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grl

State

Medical

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 ☐ Unknown

200 No

1 ☐ Yes

27. Manner of Death 1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

21014

29d. Date signed (Month, Day, Year)

02, 25, 2009

29c. License number 29b. Signature and title of certifier D0067452 MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper chesapeche Drive, Bel AIR WAJAHATH A. MOHSINI

31. Date filed (Month, Day, Year) FEB 2 7 2009

5 Pending investigation

6 ☐ Could not be

determined

. Redistrar's Signa

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM 17820b per FH G888 21/27/09 WS Health and Mehital Hygiene Certificate of Death Reg. No. 2 Date of Death cedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 3:40 AM 24 Enc 26. 2009 /Medical or Location of Death 4c. County of Death Examiner 24 Hrs. 9. Birthplace (State or Foreign Country); 7. Age (In yrs. last birthday) 9 Yrs. 8. Date of Birth (Month, Day, **Funeral** Days Hours Min **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location is marked other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1

Yes 2□No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Numbe 12. Was Decedent Ever in U.S. Armed Forces?

1) Yes 2 No IMes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) einess/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Injury or other traumatic event, 17 Eather's Name (First, Middle, Last) Brodnax Be and Mental ၉ 19b. Mailing Address (Street and Number or Rural Boute Number 19a. Informant's Name/Belationship City or Town, State, Zip Code permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau averne 20b. Place of Disposition (Name of Brodings) Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Urosepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Box 68760. Physician/Medical within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as templately filled in by the funeral director, page 2. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 1 🗆 Yes 2 No 1 ☐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C 29a, Certifier TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9006 Feb 24, 2000 nan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) st Baltimore MD 2120 Jenni N Greene uan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		1	State of Maryla State Amend Item 23a per dr., g	nd / Depa 888,02,	rtment of l	Health a Death	ınd Menta	l Hygier Reg. N	ne 2009	06114
Dhu	-1-1-	_	Decedent's Name (First, Middle, Last)				2. Dat	e of Death	Day Year	3. Time of Death
	sicia: edica		PEARL MARIE BURTON				F	EB. 1	3 2009	4:00P ^M
Exa	mine		4a. Facility Name (If not institution, give street and number) 9207 Cowenton Avenue		4b. City, Town, o			4	c. County of Deat	
Fune	eral		5. Social Security Number 6. Sex 7. Age (In yr.	s. last birthday)	If Under 1 Year	If Under 2	~	e of Birth onth, Day, Yea		hplace (State or Foreign untry)
Direc			217-60-0912 1□M XXF 89	Yrs.	Months Days	Hours	Min. Dec			ryland
and	-	_ ⊢	Usual Residence of Decedent 10a. State 10b. County 10c. County	City, Town or Lo	cation					10d. Inside City Limits
Mary a-f sho	E DOM		Maryland Baltimore	Baltimo	ore Count	.y				1 ∐ Yes 🍇 🙀 No
ith the	2		10e. Street and Number		10f. Zip Code	1100		10g. (Citizen of What Co	untry?
eath w	MBIL	runeral Directol	9207 Cowenton Avenue 11 Marital Status 12. Was Decedent Ever in	118 112 1		1128	nin? (Specify Ve	s or No-	USA 14. Race - Ame	rican Indian
Iryland 21215-UU36 should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural"; or items 23a or 28a-f show	Tall lines	DA Lau	11. Marital Status 1 □ Never Married 2 □ Married **Max Decedent Ever in Armed Forces?* 1 □ Yes 2 ★ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 □ Yes 2XXNo		Puerto Rican,	etc.)	Black, White	
Z1Z15-UU36 d within 72 hours af giene. er than "natural", or	ICSI	Delle	15. Decedent's Education	16a. Dece	dent's Usual Occu	pation	of working	16b.	Kind of Business/	Industry
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- a e	ic eve	0 00	Peter William Tremper			ι	ena Vol	.Z	,	
Ma Inthau	r trauma		19a. Informant's Name/Relationship (Type. Print) Wayne W. Burton (Son)						y or Town, State, 2 Md. 212	
Baltimore , permit. Pages 1 ar Department of Hea Important: If item?	ry or other		20a. Method of Disposition 10 Naurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Place of Dispo cemetery, cree t. Jose	esition (Name of matory or other place)	em. 2	Date 2 - 18 - 200		Location - City or Ullerton,	
baltimore permit. Pages 1 Department of H Important: If iter	any Inju		21. Signature of Funeral Service Licensee	22	Name and Addro Lassahn 7401 Bel	ess of Facility Funera air Rd	l Home . Balti	more.	Md. 2123	6
ficate be executed Medic Examin Examin Physician and Chick buriet specific	cal ner	Examiner	23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Congestive Due to (or as a conse	equenc of): ardiac quence of): Heart	mono	To the same of	cardiac or respi	ratory arrest,		Approximate Interval Between Onset and Death
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Hec he law e has b	page z snou	Completed					— L	a. Was an autopsy performed	prior to death?	atopsy findings available completion of cause of
VITAI siclan: T certificat			25. Was case referred to medical examiner?			26. Place	of Death (Chec	Yes 2.23 k only one)	No 1 ☐Yes	2 N No
(2):	F	0	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2		nt 3 🗆 DOA				6 ☐ Other (Spe	cify)
- b = 3			27. Manner of Death 1 Natural 1 Accident investigation 2 Accident investigation	28b. Time o Injury	Wo	ıryat ırk? ∃Yes 2 □1		escribe how in	jury occurred	
or A Olired	5	Certification: I	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)			28f. Lo	cation (Street y or Town, St		ural Route Number,
DIVISION To the Hospital or Attendir within 24 hours after death. To the Funeral Director; Af	erery rilled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examinand manner stated.							
To the To the To the	dwoo	Me	29b. Signature and title of certifier		29c. Licen	se number	CO	29d.	Date signed (Mont	h, Day, Year)
(4)		-	30. Name and address of person who completed cause of death (It	em 23a) (Tvno	Print)	901	ST		4/17	103
			The soul of the so			MD.	Frank1	in Squ	are Hosp	ital Center
Re	Stat gistra	•	31. Date filed (Mosth, Day, Yaar) 33. Registrar's Sig		del					

DHMH 17 Rev 1/2001

ORIGINAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year B1oom 1:28p.M 2009 02 20 Henry 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Towson Gilchrist Hospice 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Min. Months 1**∑** M 2□ F Unknowh Yrs. 60 29 <u> 215-52-3261</u> Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State 1 XYes 2 No NA Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 U.S.A. 17117 Campfield Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) UKn Unemployed Unemployed 18. Mother's Name (First, Middle, Maiden Surname) Unknown 17. Father's Name (First, Middle, Last) Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6616 Fairmount, Baltimore, Md 21215 Dianne Davenport 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

 X□ Burial
 2 □ Cremation
 3 □ Removal from State

 4□ Donation
 5 □ Other (Specify)

 Garrison Forest Vet 3/4/09 Owings Mills, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee, Skumpart Alrome 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Month Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter the carry of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mobilely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Completed Be Certification: To Medical

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be ဂ္

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be nutified at

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens important: if item 27 is marked other that any injury or other traumatic event, ITal any injury or other traumatic event, ITal any injury or other traumatic event, ITal

Physician /Medical

1 and 2 should be filed within 72 hours after death with the Maryland

				1 Ll Yes 2 L	INO 3∐ Probably 4∐ Unknown
				24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 □	Othor	eath <i>(Check only one)</i> Home 5 Residence 6	Other (Specify) Hopics
27. Manper of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □Yes 2 □ No	28d. Describe how injury	voccurred
3 ☐ Suicide 6 ☐ Could not determine		ome, farm, street, factory)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
200 Cartifior 1 Cartifular I	Physician: To the heat of my kny	owlodge death coour	ad at the time, date and play	so and due to the cause(s)	and manner as stated

State Registrar (Check only one)

29b. Signature and title of centifier 6.66)

and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) N. Chale St. Balto med 21264

address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB27

32. Begistrar's Signature

within 2 To the I

anua Nate Byi	nes	Please Type or Print in Black Indelible -McCann State of Maryland / Department	of Health and Mental Hyg	giene			
	B	For State egistrar. Decedent's Name (First, Middle,Last)		Reg. No. 2009 06 1 1			
Physician dical Examin	er /	Amanda Kate Byrnes-McCann		Month Day Year 0019 hrs February 25, 2009 4c. County of Death			
		la. Facility Name (if not institution, give street and number) 1500 Glencoe Road	4b. City, Town, or Location of Death Sparks Glencoe	Baltimore County			
Funeral Director			Yrs. If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Texas			
nd show any nce,		Journal Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo MD Howard Columbi		10d. Inside City Limits 1 Yes 2 No			
eath with the Maryland items 23a or 28a-f show	Director	10e.Street and Number 9829 Rainleaf Ct	10f. Zip Code 21046	10g. Citizen of What Country? U.S.A.			
215-0036 be filed within 72 hours after death with the Maryland nital Hygene. ked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Fune	1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F Yes 2 No specify:				
72 hours af "natural	eted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	dent's Usual Occupation (Give kind of wo g most of working life. DO NOT use retire	ed)			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after demen of Health and Mental Hygerer. Itani: If item 27 is marked other than "natural", or or other transmatic event, the Medical Examiner in	5	11 Stud 17. Father's Name (First, Middle, Last) unk	18.Mother's Name (N/A First, Middle, Malden Surname) n Ann Byrnes			
MD 2121 d 2 should be fi lth and Mental in 27 is marked aumatic event,	0	19a. Informant's Name/Relationship (Type, Print) Kathleen Byrnes/Mother 982	iling Address (Street and Number or Ri 9 Rainleaf Ct,	ural Route Number, City or Town, State, Zip Code) Columbia, MD, 21046			
Baltimore, Noemit. Pages I and Department of Health Important: If item injury or other trauming or oth		1 Burial 2 Cremation 3 Removal from State Chesap		Date 20c. Location - City or Town, State 7/2009 Beltsville, MD			
Baltimo		21 Signature of Funeral Service Licensee . VOIVU2 2	717 Green Pastu	A/Stephen D Lohrmann P. Ares Dr., Towson, MD., 21286 respiratory arrest, shock, or heart Approximate Interval			
Physician Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Asphyxia Due to (or as a consequence of):	er tile mode of dying, datal ac calculate of	Between Onset and Death			
d sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Hanging Due to (or as a consequence of): Due to (or as a consequence of):					
e executed cian and rial - transit	g	dunpended AMENDED					
Box 68760, • death certificate be exe the attending physician of for use as the burial		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3 Ectopic pregnate Other (Specify)	23d. Date of delivery Month Day Year			
ires that the designed by the	ģ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
ecords, he law requir ate has been si age 2 should b	Completed			24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 24b. Were autopsy findings available prior to completion of cause of death?			
tal Reciclans The	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpa	26.Place of Death (Check of tient 3 DOA Other Nursin	only one) g Home 5 Residence 6 ✔ Other: Scene			
n of Vit ling Physic After this funeral dir	유	1 ✓ Yes 2 No Property 22 Erosuper 22. Manner of Death 28a. Date of Injury 28b. Time 25 (MR) Day, Year) EOUND	e of Injury 28c. Injury at Work?	28d. Describe how injury occurred Subject hanged self			
~ # . ^ #	ξl	2 Accident Investigation 3 V Suicide 6 Could not be	street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State) 1500 Glencoe Road, Sparks Glencoe, MD			
lor Attendii after death. Director: △	rtifica	determined (Specify) Sphool					
Division of Vital Records, the Hospital or Attending Physician: The law requiring 4 hours after death. The Funeral Director: After this certificate has been simpletely filled in by the funeral director, page 2 should	Jical Certification:	4 Homicide determined (Specify) School 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigations.	occurred at the time, date and place, and	due to the cause(s) and manner as stated.			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exceuted within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transity.	Medical Certifica	4 Homicide determined (Specify) School 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of	occurred at the time, date and place, and	due to the cause(s) and manner as stated.			
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined (Specify) School 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only one) 2 Medical Examiner: On the basis of examination and/or invessand manner stated. 29b. Signature and little of certifier 30. Name and address of person who completed cause of death (Item 23a)	occurred at the time, date and place, and stigation, in my opinion, death occurred a 29c. License number	due to the cause(s) and manner as stated. It the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) February 25, 2009			

		For State Registrar	State of Mary		epartmer Certificat			nd Mental	Hygier	200	9	06117
Physic /Medi		1. Decedent's Name (First, Middle, Last)	am hall					2. Date of Month	h [Day Yes		3. Time of Death 6.29 AM
Exami	ner	4a. Facility Name (If not institution, give s Sound) 5. Social Security Number 6. Sex	ntan Ho	Spitos yrs. last birth	1 B	al	Location of	Me 4 Hrs. 8 Date	of Birth	Bath	mo	ve City ce (State or Foreign
Funeral Director		213-34-0262	1м 2∏ г 72		Months	Days	Hours	Min. NOV.	21, I	936	Country	MD MD
yland how		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town o	or Location						10d	I. Inside City Limits
ith the Marylan or 28a-f show	ector	MD N/A		BALTI		0-1-			10-	Cialina of Milant	Causain	Yes 2□No
3a or	al Dir	10e. Street and Number 4333 HAMILTON AVE			10f. Zip	2120	16			Citizen of What USA	Country	y :
ite, intally intallid 2.12.13-0030 stand 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ita Wedical Extrational Learn Allied 2.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2√7 No If Yes, Give Year or Dates:	in U.S.	13. Was Dece If Yes, spe 1 ☐ Yes	**	ispanic Orig n, Mexican, Specify:	in? (Specify Yes Puerto Rican, etc	or No-	14. Race - A Black, W Specify:).
72 hor	eted	15. Decedent's Educ (Specify only highest grade	cation e co <i>mpleted)</i>	(1	ecedent's Usu Give kind of wo	rk done a	luring most	of working	16b.	Kind of Busine	ss/Indu	stry
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2 should be filed with and Mental Hygiene is marked other than aumatic event, Irall	To Be C	17. Father's Name (First, Middle, Last) CHARLES BRAMHALL						's Name <i>(First, M</i> E MOWERY		en Surname)		
VICELY NOTE OF THE PROPERTY OF	0 8	19a. Informant's Name/Relationship (Ty	•	I	Mailing Address			or Rural Route N		y or Town, Stat	-	code)
permit. Pages 1 and 2 Department of Health Important: If item 27 i any injury or other tra	8	PAUL BRAMHALL-BRO 20a. Method of Disposition	2		isposition (National Crematory or control			Date		Location - City		n, State
Pages treent of the tant: If ite		1 ⚠ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		OOD CEN	ETER	RY	2/28/09		ALTIMOR		
permit. F Departm Importar any injur	8 8	21. Signature of Fungfal Service License	е		22. Name ar					L FUNER MD 212		HOME, INC
		23a. Pirt 1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the le cause on each line.	death. Do no	t enter the mod	le of dyin	g, such as c	cardiac or respirat	ory arrest,		l l	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or is a co	nsequence	y ta	Alu	ve				-	
Examiner	_	Sequentially list conditions,	Acut	€ 13	chan	110	Str	oke				O days
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12, months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pi 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 Ectopic 5 Other (s		/	*		23d. Date of Month		/ ay Year
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hysician: The law his certificate has t I director, page 2 sl	Completed	25. Was case referred to medical						1 🗆 '		prior death	to comp	y findings available pletion of cause of
ysicia ysicia nis certi directo	To Be	eyaminer?	lospital: 1 🗖 Inpatient	2 🗌 ER/Outp	atient 3 🗆 D	Othe	or:	of Death <i>(Check)</i> sing Home 5 □		6	Specify)	
ling Ph L. After th funeral	ion: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Ye	ar) 28b. Tir Inj		28c. Injury Work			cribe how in	jury occurred		
To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm pecify)	M n, street, factor		Yes 2□N	28f. Local	tion (Street or Town, St	and Number or ate)	Rural I	Route Number,
Hospita 24 hours Funeral etely filled	Medical C		sician: To the best of m ner: On the basis of exa and manner stated.	amination and	or investigation	n, in my o	pinion, deat	h occurred at the	time, date a	and place, and	due to tl	he cause(s)
To the To the To the Compl	Me	29b. Signature and title of certifier	01		29	c. License	e number		29d.	Date signed (M	onth, Da	ay, Year)
		> grafe	uch MD	/n =====	- D/ 3	P-	217	15		02/2	5/0	09
5		30. Name and address of person who co	and manner stated. MD mpleted cause of death MC: 56 32. Registrar's 8	(Item 23a) (T	ype, Print)	wes	n Blu	ed, Bal	tmar	e, MD	21	239
St Regist	ate rar	FFR 2 7 2009	Design ,	8. pa	all!							

State Registrar 30. Name and address

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31. Date filed (Month, Day, Year)

GANOHIA

DHMH 17 Rev 1/2001

Campbell

Blvd, Ste

21236

BAUTIMORE

person who completed cause of death (Item 23a) (Type, Print)

#32. Registrar's Signature

MD

4924

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician phirlee Joann Cohen 23 ieb 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Columbia Howard Howard Co. General Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🕱 F Yrs 7/12/1943 Baltimore Director 212-42-2696 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director MD Howard Jessup 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20794 8366 Peachwood Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>Ş</u> 3 Widowed 4 N Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other the any Injury or other traumatic event, I'me any Enge. Dept. of Transportation 12 Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Goldman Henry Levitt ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10373 College Square, Columbia, MD 21044 Cohen / Son Herbert 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/26/2009 Hanover, Maryland 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 22. Name end Address of Facility 21. Signature of Juneral Service Licens Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final diseese or condition resulting in death) **Physician** myocandial /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Completed 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after dearn.

To the Funeral Director: Af investigation 1 ☐Yes 2 ☐No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Approximate Interval Between Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2009 5755 Cldar Lane 32//Registrar's Signature **ORIGINAL**

20:04

10d. Inside City Limits

1 ☐Yes 2X No

State Registrar Waiter

31. Date filed (Month, Day, Year)

Atha

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Feb. Wanda Edith Coghill 25, 2009 6:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Futurecare Cherrywood Reisterstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M **X**X X F 78 216-28-3444 Director July 20,1930 Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ed other than "natural", or items 23a or 28a-f show event, the thirding Eventine to ust be notified at Director 1 ☐ Yes 🏋 🔯 No MD Baltimore Reisterstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 306 Cantata Court Funeral 21136 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes **X**X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes XX No Specify: <u>ک</u> Specify: 3 Widowed 400 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Homemaker</u> Own Home permit. Pages 1 and 2 should be filed n Department of Health and Mental Hygic Important: If Item 27 is marked other i any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allan M. Kable Margaret E. Hiltner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Jean Lee / 317 Magothy Rd. Severna Park, MD 21146 Daughter 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Druid Ridge
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State XIXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) March 2,2009 Pikesville, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Juneral Service Licens 11605 Reisterstown Rd. Owings Mills, MD21117 m 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ulrum disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. ned by the 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 ☐ Yes 2 🗹 No 2 🗆 No Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The destroying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Var. adress of person who completed cause of death (item 23a) (Type, Print) HIZA 31. Date filed (Month, Day, Year) State EED 9 7 2000 Registrar

		-	For State Registrar	State of Marylan			nt of He te of De			giene Reg. No. (2009		21
	Physicia /Medic		Decedent's Name (First, Middle, Last)	Carrie		Cur			2. Date of De Month 2	20	Year 2009		
1	Examin Funeral Director	er	4a. Facility Name (If not institution, give st 1312 Ashland 2 5. Social Security Number 6. Sex 218-42-9123	Avenue 7. Age (In yrs.	last birthday) Yrs.	Ba	ltimo riYear	re f Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ny, Year)	Co	thplace (State of	r Foreign
	ъ	or	Usual Residence of Decedent 10a. State 10b. County MD N/		ty, Town or Lo				0-3-	1945)	MD 10d. Inside Cit 1 X Yes	
	a or 28a-	al Director	10e. Street and Number 1312 Ashland	Avenue	11011110		p Code	5		10g. Citiz	zen of What Co	ountry?	
980	i within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Examinar must be rediffed at	by Funeral		2. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates:		Was Dece If Yes, spo 1 ☐ Yes	edent of Hisp ecify Cuban,	panic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify: B		
21215-0036	within jiene.	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12) 12th grade	ation completed) College (1-4or 5+) BA	(Give	kind of w DO NOT	ual Occupations done duruse retired) abled	on ring most of work	king		abled	Industry	
Maryland	be bd o	To Be C	17. Father's Name (First, Middle, Last) Charles H. Engl 19a. Informant's Name/Relationship (Type)		19h Mailir	ng Addres		8. Mother's Nam Julia d Number or Ru	Sawye	r		Zip Code)	
di.	and 2 seath and 2 sm 27 is		Martin D. Curry- 20a. Method of Disposition 1 Magurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	Son 20b. I		2 As	shlane ame of other place)	d Aven	ue Bal	20c. Loc		205 Town, State	MD
Baltii	permit. Pages 1 Department of Important: if ite any injury or ot once.		21. Signature of Funeral Service License			2. Name a	and Address	of Facility M North	arch E	ast			1202
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the deal cause on each line. Due tr (or as a consec	iali	nfa	rctio	001				Approximate Interval Betwoen and E	veen
68760,	or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	edical Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dik be tes Due to (or as a consecutive to (or a) consecutive	Type	· II	-, \(\tau \)	ease num t	obled	(1995	
.O. Box 6	s that the death certific ned by the attending p s detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ To 9 □ Unknown	c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of 9 Unknown	al death 3 🛭	☐ Ectopic ☐ Other (s	pregnancy specify)			2	23d. Date of de Month		'ear
rds, P.	w requires that been signed to should be deta	þ	Part II. Other significant conditions conf	ributing to death but not res	sulting in the u	nderlying	cause given	in Part I.		obacco us Yes 2	1	the cause of d robably 4 □ U	
of Vital Records,	ilclan; The law re certificate has be ector, page 2 sho	Completed	morbid Obe	sity					1 ☐ Yes	psy ormed? 2 No	prior to death?	utopsy findings a completion of ca s 2 \(\sum \) No	available ause of
f Vit	nysician; nis certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2 I] ER/Outpatier	nt 3 🗆 🛭	Othor	26. Place of Dea 4 ☐ Nursing H	ome 5 Sees		Other (Spe	ecify)	
Division o	tending Pheath.	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	М		at es 2 □ No	28d. Describe				
Divi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi		4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ify) 			data and place	City or To	wn, State)		ural Route Num.	ber,
	To the Hospital within 24 hours a To the Funeral completely filled	edical		er: On the basis of examin and manner stated.)
	To the within to the complex c	M	29b. Signature and title of certifier	mi)			0460		Febr			009
	7		30. Name and address of person who cor	npleted cause of death (Ite	m 23a) (Type,	Print)	Amo	nove	dman	212	-11		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	box	1				7.		

			1 – For State Registrar	State of Marylan	-	artment of H rtificate of D		*	giene Reg. No. 201	09 06122
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Horace F. Comegna			# 6" T		2. Date of Dea	y 22, 2	Year 7,487M
1	Examin	er	4a. Facility Name (If not institution, give st Union Memorial Hospital			4b. City, Town, or	Baltimo	re	4c. County o	N/A
ì	Funeral Director		216-42-2665	7. Age (In yrs.)	Yrs.	Months Days		Hrs. 8. Date of Birt (Month, Pa 07-02-19	43 ^(ear)	Birthplace (State or Foreign Country) Maryland
	Maryland -f show iled at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland N/A		y, Town or Lo	Baltimore	-			10d. Inside City Limits 1 🖾 Yes 2 □ No
	with the	Il Directo	10e. Street and Number 6013 Glenoak Avenue			10f. Zip Code 212	214		10g. Citizen of W	hat Country?
36	s after death ", or items 2	by Funeral	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1		Was Decedent of His If Yes, specify Cubar 1 □Yes 2 🏿 No	spanic Origin n, Mexican, P Specify:	i? (Specify Yes or No- Puerto Rican, etc.)	14. Race Black Specify:	- American Indian, c, White, etc. White
1215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Mcdral Even The Court by million at	Completed t	15. Decedent's Educa (Specify only highest grade	tion	(Give life. l	dent's Usual Occupa kind of work done do DO NOT use retired)	ition uring most of	f working	16b. Kind of Bus Baltimore	
Maryland 21	s 1 and 2 should be filed w f Health and Mental Hygie item 27 is marked other t other traumatic event, th	To Be Co	12 17. Father's Name (First, Middle, Last) Horace A. Comegna		10110			Name (First, Middle, rgaret Diddl	Maiden Surname	
	and 2 shou ealth and M n 27 is ma ner trauma		19a. Informant's Name/Relationship (Type Barbara P. Comegna - Wi					or Rural Route Number Altimore, Mar		
Baltimore,	e = ;		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State 20b. P	Place of Dispo emetery, cren t Holy I	sition (Name of matory or other place Redeemer Cen	etery	Date 02-25-2009	20c. Location - C Baltimore,	City or Town, State Maryland
Balti	permit. Pa Departmen Important; any Injury once.		21. Signature Funeral Service Licensee	inf		2. Name and Address Conard J. Ru	•		ford Road e, Marylar	nd 21214
-	Physician	y 1	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (Final disease or condition esulting in death)	ations that caused the death cause on each line.	n. Do not ent	er the mode of dying	such as ca	1	rest,	Approximate Interval Between Onset and Death
	Medical Examiner cian and private transit	Examiner	Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence to (or a conse	uence of):	edy D	Stree	s Syd	me	4 days
8/	ys e	ical	resulting in death) Last	Due to (or as a consequ	repre of):	of Fel	Va.			Vokroun
O. Box 6	the death certificate y the attending physi ched for use as the I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date Mon	e of delivery tth Day Year
rds, P.	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions control	ibuting to death but not resu	ulting in the u	nderlying cause give	n in Part I.		obacco use contril	bute to the cause of death? 3 ☐ Probably 4 ☑ Unknown
Hec	12 m	Completed						24a. Was a autop perfor 1 □ Yes	sy pr med ∂ de	/ere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 27 No	spital: 1 Inpatient 2	ER/Outpatier	ot 3 🗆 DOA Othe	r.	Death (Check only of ng Home 5 ☐ Resid		r (Specify)
lon of	nding Physician: The ath. r: After this certificate h. e funeral director, page	ation: To	27. Manner of Death M☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	f 28c. Injury Work'		28d. Describe h	ow injury occurre	
Division	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (S City or Tow		r or Rural Route Number,
	he Hospit in 24 hour he Funer pletely fill	Medical		cian: To the best of my kno er: On the basis of examina and manner stated.						
	To t To tl	Ž	29b. Signature and the of certifier	1		29c. License	number V380	146	Date signed	(Month, Day, Year)
7			30. Name and address of person who com	which mi) (Join M	Lenor	101 Hor	Pital	MI
E	Sta Registr		31. Date filed (Moeth, Day, Year)- FFR 2 7 2009	2. Registrar's Signa	ure face	Red			(,,)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 22, 2009 **Physician** Louann Beatrice Coulson 11:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 7. Age (In vrs. last birthday) 65 vrs If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth
Jun. 5, 1943 **Funeral** 9. Birthplace (State or Foreign Days 1 □ M 2 □ F Months Hours Michigan Director 549**-**21**-**1040 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any Injury or other traumatic event, the Medical Examinar must be notified at 28a-f shov MDAnne Arundel Severn 1 □Yes X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1414 Larch Road 21144 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 🔏 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 □Yes X□No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ceramics Crafts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 024 7 Y Be Leroy Arnold Swanson Lucille Valores 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Coulson - Husband 1414 Larch Road, Severn, MD 21144 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State MD"Verterans Cenletery 2-27-2009 Crwonsville, MD 4 □ Donation 5 □ Other (Specify) **(**a Orownsville 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature I Fune it Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hour MYOCARDINI TAIR ANCIT UN / /Medical Due to (or as a consequence of): Examiner ATIMONUSCLINOTIC CARNIO UDSCULAR 412m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DISTIASTE Examiner Due to (or as a consequence of) requires that the death certificate be executed and Due to (or as a consequence of) the attending physician hed for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Ď 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 27. Manner of Deal 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No eral Director; / 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Sign ture and title of certifie 29d. Date signed (Month. Day, Year) 127838 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIX CAME MEANIN RUMS! JOITNI SIMPLEMS 7.0 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **FEBRUARY** 2009 LOUISE BLANEY COMPTON

Months

7. Age (In yrs. last birthday)

10c. City, Town or Location

Bel Air

Bel Air

10f. Zip Code

21014

Days

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

11:20 A M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☑ Yes 2 ☐ No

Maryland

4c. County of Death

Harford

10g. Citizen of What Country?

8. Date of Birth (Month, Day, Year)

28, 1913

USA

Physician /Medical Examiner 1 - For State Registrar

10a. State

Funeral Director

5. Social Security Number

214-01-2392 Usual Residence of Decedent

10e. Street and Number

Maryland Harford

4a. Facility Name (If not institution, give street and number)

10h. County

230 Crocker Drive

230 Crocker Drive Apt. B

6. Sex

1 M 2 T

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Apt. B

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Evan Instruct be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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11. Marital Statu	s	12. Was Decedent Ever in U. Armed Forces?	ecedent of Hi specify Cuba	spanic Origin? (S n, Mexican, Puerl	 Race - Ame Black, White 	American Indian, White, etc.			
_	arried 2 Married	1 □Yes 2 ▼No	1 □ Y€	s 2√∏No	Specify:		S	Specify:	
	d 4 Divorced	Year or Dates:							White
Elementary/S 12 17. Father's Nar	15. Decedent's Ed pecify only highest gra	ducation ade completed)	16a. Decedent's (Give kind of	Usual Occupa of work done of	ation <i>luring m</i> ost of wor)	rking	16b, Kind	d of Business	/Industry
Elementary/S	econdary (0-12)	College (1-4or 5+)	House W		,		Oram	Home	
17. Father's Nar	ne (First, Middle, Last,)	House W.	116	18. Mother's Nar	me (First, Middle,			
Char	les Archer	Blaney			Edith F	rances Z	achar	- 'Y	
19a. Informant's	s Name/Relationship (Type. Print)	19b. Mailing Add	iress (Street	and Number or R	ural Route Numb	er, City or	Town, State, .	Zip Code)
20a. Method of Burial	Ta B. Warfi Disposition 2 ☐ Cremation 3 ☐ on 5 ☐ Other (Special	Removal from State	1914 Graphics of Disposition temetery, crematory	(Name of or other plac	2-2	d, Fores 6-09	20c. Loca	ation - City or	21050 Town, State
21. Signature o	f Funeral Service Lice		22. Nan McCo	ne and Addres	s of Facility ineral Ho	ome, P.A		- 22	land 21009
23a. Part 1. Ent shock, or Immediate Cau disease or con- resulting in dea	heart failure. List only se (Final dition	plications that caused the deat one cause on each line. a. Due to (or as a conse	acti-	mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Betwee Onset and Deat
Sequentially list if any, leading to cause. Enter U Cause (Disease that initiated ev- resulting in dea	nderlying	b Due to (or as a conseq c Due to (or as a conseq d	·						
IF FEMALE: 23b. Was decein the past 1 Yes 9 Unknown	12 months? 2 □No	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	il death 3 ☐ Ecto	opic pregnanc er (specify) _	/		23	3d. Date of de Month	elivery Day Year
Part II. Other si	gnificant conditions	contributing to death but not res	ulting in the underly	ing cause give	en in Part I.				o the cause of death
						24a. Was auto perfo 1 □Yes		24b. Were a prior to death?	utopsy findings avai completion of cause s 2 No
25. Was case r	eferred to medical				26. Place of De	ath (Check only o	one)		
examiner?		Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Oth		Home 5 🔀 Resi		☐Other (Spe	ecify)
27. Manner of D 1 Natural 2 Accider	5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur Worl	yat (? Yes 2 ∐ No	28d. Describe			
1 Yes 27. Manner of E 1 Natural 2 Accider 3 Suicide 4 Homicid			ome, farm, street, fa	actory, office		28f. Location (City or To	Street and wn, State)	Number or R	lural Route Number,
29a. Certifier (Check only one)		hysician: To the best of my knominer: On the basis of examination and manner stated.							
	and title of certifier			29c. Licens	e number		29d. Date	signed (Mon	th, Day, Year)

State Registrar LITW.

D32229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6:20 P M Robert James Crytser Sr. February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours Min 1⊠M 2□ F Director 89 185-18-8910 Oct. 10, 1919 Pennsylvania Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours affer death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1003 Prospect Mill Road 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Supervisor U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Elmer Crytser Eva (nmn) Hunt ဝ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara O. Crytser / Wife 1003 Prospect Mill Rd., Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calvary U.M.C. Cem. 2-27-09 Churchville, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon

23a. Part1. B ter the disease, or complications that caused the death. Shock, or heart failure. List only one cluse on each line. 1317 Cokesbury Rd., Abingdon, MD 21009 Approximate Interval Between Onset and Death Immediate Cause (Final Severe **Physician** preumania disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leafung to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine for use as the burial-trans Due to (or as a consequence of): 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) sate has been signed by the a page 2 should be detached it 1 ☐ Yes 2 ☐ No Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. \$ bacteremia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy death? 1 □ Yes performed' CVA 2 11No 1 □ Yes 2 110 Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospitai or Attendii within 24 hours after death. To the Funerai Director: A completely filled in by the fu death. investigation 1 □Yes 2 □ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and fittle of eertifier 29d. Date signed (Month, Day, Year) asin 063420 February 23, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper chesapeake or Bel Air, MD 21014

State Registrar 31. Date filed (Month, Day, Year)

32. Begistrar's Signature

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND, ITEM#30perDVR, G888, 2/2/109, WS State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Reg. No. ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 9:09 PM /Medical (If not institution, give street and number, Town, or Location of Death County of Death 4c Examiner Battimore 6. Sex 1 M 2 □ F If Unde Date of Birth (Month, Day) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours Director Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d, Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be indiffed at once. 1 XYes 2 □ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give/ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Be ပ 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keisterstown, nise 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 □ Other (Specify) Funeral Sive 21. Signature of Funeral Service L 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** ensive /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of Yes 2 No Yes 2 🗆 No Hospital or Attending Physician: 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical exampler? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Mani er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determin 4 Homicide 1 24 hours a The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 and manner stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D5434 telemeny 2009 MD of person who completed cause of death (Item 23a) (Type, Print) Randallstown, MD nashan Northwest Hosp Ctr. 5401 01d Court Rd 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mai	ryland / Depa <i>Cel</i>	rtificate of		лептат тус т	Reg. No. 200	9 06127
	Physicia	ın	1. Decedent's Name (First, Middle, L					2. Date of Dea	ath Day Ye	3. Time of Death
	/Medic	al	Anne Frydman Dixe			4h City Town, o	r Location of Death	Februar	4c. County of D	
1	Examin	er	1315 Boyce Ave.	wo offeet and nameer,			lowson		Baltimo	ore County
	Funeral Director		109-38-5243	Sex 7.Age 1 □ M 2 🖾 F	(In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da May 27	9. Y, Year) 1947 Ne	Birthplace (State or Foreign Country) WYOTK, N.Y.
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	e Mary	ctor		ore County	Towson					1 □Yes 2Å No
	th with th	Funeral Director	10e. Street and Number 1315 Boyce Ave.				21204		10g. Citizen of What United S	
036	1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, in Medical Evertinar must be collined at		11. Marital Status 1 ☐ Never Married ②□ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ex Armed Forces? 1 ☐ Yes 2∑No If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cuba 1 □Yes 2□No	dispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specify:	American Indian, Vhite, etc. White
Baltimore, Maryland 21215-0036	within 72 ho ene. than "natu	Completed by	15. Decedent's (Specify only highest statementary/Secondary (0-12)	Education grade completed) College (1-4or 5+	(Give		oation during most of work d) ciate Pro			ess/Industry Hopkins ersity
ام 2	e filed al Hygi other vent, I	BeC	17. Father's Name (First, Middle, La	st)					Maiden Surname)	
ylaı	ould by Menta	입	Gregory Frydman				Gusta W			As Zin Codel
Mai	nd 2 sh afth and 27 is m r traum		19a. Informant's Name/Relationship ivir.Stephen Bruce		l l	ng Address (Street .5 Boyce 7			er, City or Town, Sta Maryland	21204
more,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐ Removal from State	20b. Place of Dispo cemetery, cre Evans Fur	osition (Name of matory or other place eral Cha	ce) Feb	Date 25,	20c. Location - City Forest F	orTown,State Hill,Maryland
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service Life	- Har la	2 P6 2	2. Name and Address aceful A. 325 York	ess of Facility lternativ Road	es Fune Timoniu	ral&Cremat m, Maryla	tion Ctr.,P.A.
ı			23a. Part . Enter the sease, or co shock, or flear f, lure. List on	intelications that caused to ly one cause on each line	the death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
Same of	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a	TORY FAIL consequence of):	URE				-
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	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		echsequenes of):	ATT A				
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68760,	ificate I g physics the b	edical		d						
P.O. Box	ath cer ttendin or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 l	⊒ Ectopic pregnand ⊒ Other (s <i>pecify)</i> _	cy		23d. Date o Month	
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Division of Vital Records,	: The law require cate has been sig page 2 should b	Completed						24a. Was autor perfo 1 □ Yes	osy prio ormed? dea	re autopsy findings available r to completion of cause of th? Yes 2 □ No
VIII	sician certifi irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	nt 2 ☐ ER/Outpatie	nt 3 🗆 DOA Oth	26. Place of Dea ner: 4 ☐ Nursing H	1/	one) dence 6 □Other ((Chapita)
ion of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Certification: To	27. Manner of Death Natural 5 Pending 2 Accident investigat	28a. Date of Injur (Month, Day	y 28b. Time o	of 28c. Inju	ry at		how injury occurred	<i>Зресну)</i>
Divis	al or Atte s after des al Directol ed in by th	Certifica	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At home, farm, st . (Specify)	reet, factory, office	- 11	28f. Location (City or To		or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical (29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best of xaminer: On the basis of and manner state	examination and/or i	th occurred at the to nvestigation, in my	ime, date and place opinion, death occu	e, and due to the irred at the time,	date and place, and	due to the cause(s)
	To t With To t	Σ	29b. Signature and title of certifier	A ann	A	29c. Licen	se number		29d. Date signed (A	Month, Day, Year)
	V		30. Name and address of person w	no completed sause of de	eath (Item 23a) (Type	Print)	17(03		ayat	1-1
	15 1		CHARLES S. ANGE	LL, M.D., 10	755 FALLS		200, LUT	HERVILLI	E, MD 210)93
	Sta Registi		31. Date filed (Month, Day, Year)	2009 32 Registra	r's Signatur	ak				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Andrew Ignatius Dickard, Jr. February 25, 2009 3:50 P. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | April 21, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months **№** 2□ F Maryland 84 213-20-4386 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2/CXNo Harford Bel Air Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21015 United States 2110 Ruffs Mill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1√Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registrar Catholic Church 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Andrew I. Dickard, Sr. Alice A. Ward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 Misty Hill Dr. Delta, Pennsylvania 17314 Karl Schalk / Nephew 20b. Place of Disposition (Name of Evans Funeral Chapel Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/03/2009 4 Donation 5 Dother (Specify) Bel Air Forest Hill, MAryland 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service—BelAir 21. Signature of Funeral Service Licensee 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sertic Shock disease or condition resulting in death) Due to (or as a consequence of) neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown embolism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 🖽 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation

Examiner attending physician and for use as the burial-trar nse signed by the a o Records, peen has of Vital funeral director, After this i or Attending I after death. Division the Director: filled in

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permit. Pages 1 and 2 a Department of Health a Important: If item 27 is any injury or other trau once.

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/Medical

Baltimore, Maryland

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 27. Manner of Death

1 Natural 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide

and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 🗌 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

0 63420

February 25, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 Upper Chesapeake Dr. Bel Air MD 21 Siddig Zubaic 31. Date filed (Month, Day, Year) Kharal

State Registrar

DHMH 17 Rev 1/2001

To the Hospital of within 24 hours at To the Funeral D

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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 02 22 Day **Physician** 2009 Evans 10:05a M Louise Margaret /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Sinai Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 💢 F Director 218-46-8542 61 MD 18 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
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1 ☐ Live birth 2 ☐ Fetal death
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2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: de 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address # person wh 38 EDMONDSON 0 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician Robert F. E₁y 2009 7:25 p. M February 23, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Bedford Court Nursing Center Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 0278791525 Months 1 X M 2 □ F 84 112-16-8246 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be rediffed at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 XNo Silver Spring Montgomery Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20906 3701 International Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Xiyes 2 Now II If Yes, Give WW II 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛛 No Specify: White Specify: δ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) College Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) å Margaret Mulvey Frank Ely ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4609 Westhill Rd. Ellicott City, MD 21043 (daughter) Patricia Kamsa 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 2/25/09 Beltsville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Services 21. Signature of Funeral Service M00382 Dunuan 20910 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition PNEUMONIA 3 days **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Cerebro vascula, Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): burialthe attending physician Box 68760 Physician/Medical the as IF FEMALE: use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year for Day 5 Other (specify) P.0. ☐Yes 2 No detached 9 I Inknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an per Tensis autopsy performed? Yes 2 No 1 ☐Yes 2 ☐No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 42 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day, Year) Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

ne Hospital or Attending Pin 24 hours after death. completely To the 1 within 2. To the F

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MRTHUR 31. Date filed (Month, Day, State

29a, Certifier

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Drive, String, MD 20832 Sansencon MO

and manner stated.

Registrar

Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Gretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

Second S	Eugene Fox Physicial	n/	Please Type or Print in Black Indelible Ink. Ens State of Maryland / Department of Health For State Registrar Certificate of Death Decedent's Name (First, Middle, Last)	and Mental Hy	rgiene Reg 2. Date of Death	. No. 200	1-06132
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Security 1986 1987 198	fter death w I", or items ner mus b		1 Never Married 2 Married Armed Forces? If Yes, specify Co	uban, Mexican, Puerto F		White, etc.	
Security 1986 1987 198	36 in 72 hours fran "natur dical Exam		Elementary/Secondary (0-12) College (1-4 or 5+)				
Mrs. Virginia L. Hawk/ mother 12219 Falls Road Cockeysville, Maryland 21030	다 글 뜻 를 다	Be	17. Father's Name (First, Middle, Last) Kirk Hoffman Fox	Virgini	a Louis	aiden Surname) e Crue	
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AMENDED 23a,27,28a=f, perME, g889 3/31/09 TT Second Column Co	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			10	
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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. Pebruary 26, 2009	n of Vit ding Physic After this (의	1 ✓ Yes 2 No	. Injury at Work?	28d. Describe ho	ow injury occurred	
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. Pebruary 26, 2009	Divisio ital or Atten irs after deatl ral Director: lled in by the	ertificati	2 Accident Investigation 3 X Suicide 6 Could not be determined (Space it) residence	fice building, etc.	28f. Location (St	treet and Number or Ru	ıral Route Number, City
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	F \$ F 0	ž	29b. Signature and title of certifier 29c. Li C				
State 31. Date filed (Month, Day, Year) 32. Kegistrar's Signature			Russell Alexander MD. Assistant Medical Examiner 111 Penn Str	eet, Baltimore, MI	D 21201		

09-01641

	-	For State	State o	of Marylan	•	rtment of F	lealth and N Death		2111)9	0613	33	
		Registrar 1. Decedent's Name (First, Middle, I	Last)					2. Date of Dea					
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/Medic Examin		4a. Facility Name (If not institution,		ımber)		4b. City, Town, o	r Location of Death	rebrae	4c. County		0.00	<u>Ju</u>	
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Funeral			. Sex 1 □ M 2 🔀 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	Country		oreign	
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partition (e), Intal yial to ZIZI3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, I'm Modicel Examination in official once.	Funeral Director	11. Marital Status 1 ☐ Never Married 2X Marries	Armed Fo	2 XNo	1	Was Decedent of F f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Blac	e - American k, White, etc			
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Jid be Jenta Jenta rked tlc ev	10 B	George Sroka	Cecel	ia Ros	inska								
and Nama	Г	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numb	er, City or Town,	State, Zip C	ode)		
and		Deborah Fodel	(daugl				rt Perry						
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t. Pag tmen tant: ljury	١.,	4 □ Donation 5 □ Other (Spe	ecify)	St			Cem 2-28						
permit. Departit Imports any Inji		21. Signature of Funeral Sovice Icensee 22. Name and Address of Facility Kaczorowski Funera 1201 Dundalk Avenue Baltimore,											
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		30. Name and address of person w	no completed car	use of death (Ite	m 23a) (Type,				Balti				
Ψ		Davis M. Hahr	1, M.D.	5601	Loch :	Raven B	lvdSu:	ite 10:		2123			
St Regist	ate rar	31. Date filed (Month, Day, Year)	ma &	Registrar's Sign	A. ba	wed .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	of Maryland / Dep	rtificate of De		$^{\text{giene}}_{\text{Reg. No.}} 2009$	06134							
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15			The Johns Hopkins Hospital 5. Social Security Number 6. Sex		Baltimore C		4b	1) -1 (04-4							
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Maryland 21215-0036	hin 72 h e. an "natu Medical	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	d) (Give	edent's Usual Occupation e kind of work done durir DO NOT use retired)	n ng most of working	16b. Kind of Business	s/Industry							
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an	sho and l		19a. Informant's Name/Relationship (Type. Print)	{		Number or Rural Route Numb									
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Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra		20a. Method of Disposition 1	m State 20b. Place of Disposer cemetery, cre Oaklaw	amatoni or other olace)	y 2-28-2009	20c. Location - City of Balto Co								
Balti	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202												
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c.			shock, or heart failure. List only one cause on each line. Immediate Cause (Final												
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	3		30. Name and address of person who completed o	ause of death (Item 23a) (Type	, Print)		*,								
	4	4	thlang 12 mones, MD			600 North Wo	olfe St, Baltim	ore, MD, 21287							
	Sta Registr		31. Date filed (Month, Day, Year)	Registrar's Signature	who										

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<i>'</i>	Funeral		5. Social Security Number 6. Sex	7. Age (lr.	yrs. last birtho	day) If Under 1	Year	If Under 24		ate of Birth Month, Day		_	nplace (Stat	e or Foreign		
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			23a. Part 1. Ent - the disease, or complice shock, or heart failure. List only one	ations that caused the cause on each line.	death. Do no								Approxir Interval	nate Between nd Death		
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):													
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Ó	ertificate ing phy as the	Medic	IF FEMALE:													
O. Box	he death certific the attending p shed for use as	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1								Day	Year				
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ion	Attending Physician: The lar death. ector: After this certificate hiby the funeral director, page	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Y	(ear) 28b. Ti	jury M	8c. Injur Work 1 🗆	yat ⟨? Yes 2 □ N		Describe	now injui	ry occurred				
Divis	5 # 5 E	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, far (Specify)	farm, street, factory, office 28f. Location (Str. City or Town,						reet and Number or Rural Route Number, n, State)				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director,	Medical (29a. Certifier 1 Certifying Phys (Check only one)	siclan: To the best of oner: On the basis of eand manner state	xamination and	death occurred dor investigation	at the ti	me, date an pinion, deal	d place, and th occurred a	due to the	cause(s date an	s) and manner a d place, and du	s stated. e to the cau	se(s)		
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			I muyu And	0	n. 9		リ	005	1158		FETS	RUBRY	24	2009		
1			30. Name and address of person who co	mpleted cause of dea			r	ΩΛ	(Y ul	1115	٢	10208	17			
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's				120	<u></u>			- 200				
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			For State Registrar	State of Marylan		artment of F rtificate of I			ene g. No.2009	06136				
	Physici: /Medic		1. Decedent's Name (First, Middle, Last) Lawrence	Thomas	Go∈	etz		2. Date of Death Month Day Year FEBRUARY 24, 2009 6:200 M						
)	Examin		4a. Facility Name (If not institution, give s Saint Joseph		nter	4b. City, Town, or	r Location of Death Tows	son	4c. County of Dea	h ltimore				
	Funeral Director		220 21 0000	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay) 7/03/19	year) 9. Bir 28 Mary	thplace (State or Foreign puntry) Land				
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits				
	a-f sh	ctor	Maryland Baltimore		Essex					1 □Yes 2□No				
	or 28	Director	10e. Street and Number			10f. Zip Code		10	10g. Citizen of What Country?					
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examirar must be rotified at ance.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: 1946		If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, White					
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212	d withir giene.	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	1	er/Operat			Taver	m				
pu	be filed tai Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)	Coots			18. Mother's Name	(First, Middle, Mi	aiden Surname) (unknowr					
Maryland	d Men marke matic	၉	Christopher	Goetz	10h Mailie	an Address (Ctrast	and Number or Due	Mary	City or Town, State,	<u> </u>				
Ma	nd 2 sl ulth an 27 Is r r traur		19a. Informant's Name/Relationship (Type Christopher Goetz			· .			yland 2101	_				
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Ē	Page ment (ant: If ury or		1 ☐ Burial 2 🖾 Cremation 3 ☐ R 4 ☐ Denation 5 ☐ Other (Specify)	emoval from State Bay	yview (Crematory	Inc 2/28		altimore M	The state of the s				
Baltimore,	permit. Depart Import any inj		21. Signature of Funeral Service License	人	ُ اِ د	1407 old	Eastern A	venue Es	i Funeral sex Maryla					
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O. Box	Attending Physician: The law requires that the death certificate be executed rideath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. Date of de Month	f. Date of delivery Month Day Year									
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ord	w require s been sl should b	ted						1 🗆 Yes	s 2 No 3 □ P	robably 4 Unknown				
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tal	ysician: The lar Is certificate has director, page 2		25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2 h (Check only one	DANO 1 □Yes	3 BNO				
Į <	Physici this cer al direct	Fo Be	examiner?	ospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Oth	er:		nce 6 Other (Spe	ecify)				
o u	ding Pi T. After ti funeral	.io	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Wor		28d. Describe how	v injury occurred					
isic	of or Attend after death Director: d in by the f	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, sti		Yes 2 □No	28f. Location (Stre	eet and Number or R	ural Route Number,				
<u>S</u>	j ig fe	Certification: To	4 Homicide determined	building, etc. (Speci	fy)			City or Town,	State)					
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (lician: To the best of my knower: On the basis of examination and manner stated.										
	To t With	29b. Signature and title of certifier Clynulos D25886 29c. License number D25886								2009				
	6+1		30. Name and address of person who co	mpleted cause of death (Iter	m 23a) (Type,	Print)								
	U '	te	31. Date filed (Month, Day, Year)	M D 76.1711 32. Řegistrar's Signa	OSLE	R DRIVE	TOWSON,	MARYLA	AND STEW	4				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per Fh g890 4/2/09 TT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 21, 2009 **Physician** Month 6:00 GORDON February CASHMA TSTAH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Northwest Hospital Seasons Hospice Randallstown Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1⊠M 2□F Director 124-56-8097 37 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Machael Extra frue traumatic event, Director 1 XYes 2 No Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21229 1 Monastery Avenue U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼No 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Black Specify If Yes Give þ 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Credit Union permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygin Important: If Item 27 is marked other any Injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isiah Gordon Dorothea K. Epps ပ္ 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 540 E 169th Street, Apt. 6F Bronx, NY 10456 19a. Informant's Name/Relationship (Type. Print) Isiah Gordon (Father) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oxford Hills
Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2-25-09 Chester, NY 22. Name and Address of Facility Unity Funeral Chapels, Inc. 2352 8th Ave., NW New York, 21. Sign ture of Funeral Service Lic Ase Umun NY 10027 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Wennerally /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a I be detached f 1 □Yes 2 □No 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Known should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has t autopsy performed certificate 1 ☐Yes 2 ☐ No 1 □ Yes 2 □ ★ C To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | → After this of funeral dire 15 depatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No the Funeral Director: npletely filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier COU 21/39 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mille Sweet Sinte 31 Date filed (Month, Day, Year) 32. Registrar's Sig ature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Month **Physician** Eula Mae Gregory Feb 21 2009 2:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner hospital Baltimore N/A Agnes If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Sep. 10, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2√2 F 414-42-2972 78 Virginia Director Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d Inside City Limits 10a State Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show lant: If item 27 is marked other than "natural", or items 20 or 20 1 □ Yes 2 No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5909 Oakland Road 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: White If Yes, Give Year or Dates: Specify Completed by Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cartography Data Entry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Wesley Steele Elizabeth Bird ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda Overby - Daughter 104 Hiview Drive, Nottingham, PA 19362 20b. Place of Disposition (Name of Meadow 11dge) Menior 1al Method of Disposition 20c. Location - City or Town, State 1 Bukial 2 □ Cremation 3 □ Removal from State Department of Important: If any Injury or once. 2-27-2009 4 ☐ Domation 5 ☐ Other (Specify) Elkridge, MD Park re of Furleral Se vica License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final is chemic rerebrovascular accident cute **Physician** day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hyperterision ulai Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ boillamon 1 | Yes 2 | No 3 | Probably 4 | Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 NO spital or Attending Physician: The hours after death. Inneral Director: After this certificate y filled in by the funeral director, par 1 ☐ Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) edels

State Registrar

DHMH 17 Rev 1/2001

Registrar FFR 2 7 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

81

Boddu

31. Date filed (Month, Day, Year)

hospital

900 S Caton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Lola M. Gill ebruary 200 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, umber 1emoria AMPUS If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 05/23/1924 7. Age (In yrs. 5. Social Security Numbe Months Days Hours Min 84 218-18-3363 (Unknown) Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2 No Allegany Cumberland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21501-United States 10301 Christy Rd. NE 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 🗷 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland State Governm Elementary/Secondary (0-12) College (1-4or 5+) Civil Servant (Unknown) (Unknown) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (Unknown) (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Renee Kniseley/Gaurdian 19 Frederick St. Cumberland, MD 21502-20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Feb 25 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bethesda, Maryland 2009 4 ☑ Donation 5 ☐ Other (Specify) Uniformed Service Univ. 22. Name and Address of Facility Rapp Funeral & Cremation Services MU038Z Silver Spring, Maryland 20910-933 Gist Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of). 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) a 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗹 No 1 ☐Yes 2 ☐No 1 ☐ Yes 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examirer must be notified at

Director

Funeral

2

Completed

Be

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Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

* Natural

2 Accident

4 Homicide

3 Suicide

5 Pending

investigation

6 Could not be determined

Year)

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "natural" ---- any injury or other traumatic event

/Medical

10a State

MD

and for use as the burial-transi attending physician or Attending Physician: The law requires that the death certificate be cate has been signed by the page 2 should be detached certificate this funeral After after death. the filled in by within 24 hours a

To the Funeral L

P.O. Box 68760,

Division of Vital Records,

To the Hospital

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manuer of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

12

completely

Date filed (Month, Day, 32. Registrar's Signature 28f. Location (Street and Number or Rural Route Number, City or Town, State)

			for State Registrar	State of M	arylan		artment <i>rtificate</i>			and M		iene _{9. No.} 2 (009	06140	
-	Physici /Medic		ALVIN				GORN 2. Date of Dea						3. Time of Death 10:18 А м		
	Examin	er	4a. Facility Name (If not institution, g NORTH OAKS HEAL		4b. City, To		SVILL				4c. County of Death BALTIMORE				
	Funeral Director		215-16-6341	Sex 1 M M 2 □ F	<i>ast birthday)</i> Yrs.	If Under 1 Months I	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month Day, 07/17/1	921				
ind 21215-003(be filed within 72 hours a tal Hygiene. d other than "natural", o	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD BAL 10e. Street and Number 725 MT. WILSON I 11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced 15. Decedent's I (Specify only highest g Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Lass SAMUEL 19a. Informant's Name/Relationship	12. Was Decedent Armed Forces? 1 Myes 2 If Yes, Give Year or Dates: Education rade completed) College (1-4or 5	Ever in U.S. No WW I	16a. Decec (Give life. L	Was Decedent of Hispanic If Yes, specify Cuban, Mexical Occupation & kind of work done during machine by Control of the Kernel of the Kernel of Work done during machine kind of work done during machine kind of Work done during machine by Control of Wor			t of workin	ecify Yes or No-Rican, etc.) ng (First, Middle, N	Specifi 6b. Kind of B MANU Taiden Surnan City or Town,	can Indian, etc. ITE dustry URING CHIRCUS			
	Pages 1 and 3 tment of Health tant: If Item 27 jury or other tr		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Spec	ify)		725 Nace of Disposemetery, crent.	sition (Name natory or othe	of er place)	2/26	/2009	REISTE	City or To	wn, State	
Ball	permit Depart Import any inj		21. Signaturi of Furieral Service Lice 23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused	the death	115		REIS	STERS	TOWN		PIKESV		, INC., MD 21208 Approximate Interval Between	
/Medic Examin	Physician Medical Examiner	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or influry that initiated events resulting in death) Last Onset and Death Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):												
P.O. Box 68	ath certi ttending or use a	Physician/Med									23d. Date of delivery Month Day Year				
ords, P	w requires that the dess been signed by the a should be detached to	ρ	Part II. Other significant conditions	nderlying caus	n in Part I.			cco use contribute to the cause of death?							
Division of Vital Records,	an: The law tificate has b or, page 2 sh	e Completed	25. Was case referred to medical	Tu .					26 Blace	of Dooth	24a. Was an autopsy perform 1 Tyes 2	ed? LYNo	Were auto prior to co death? 1 ∐Yes	psy findings available mpletion of cause of 2 □ No	
Ž	hysicii his cer I direct	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 🗆 I	ER/Outpatien	t 3□DOA	Othe	r: /		ne 5 🗆 Reside		er (Specil	(y)	
ouc	ding P h. After t funera	ion:	27. Mannel of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		28b. Time of Injury	28c	Injury Work?	at es 2 □ l		8d. Describe how	v injury occur	ed		
Divisi	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To	2 Accident investigation 3 Suicide 6 Could not determined	oe Diago of Init	ury - At ho c. <i>(Specify</i>	me, farm, stre			63 2		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
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	To the within the complete com	Σ	29b. Signature and title of certifier	enD			29c. L	icense	number 746	,5 .	29	d. Date signe	d (Month, 4/0	Day, Year)	
			30. Name and address of person who N. S. Rajapaks	completed cause of d	eath (Item	23a) (Type, I	Suite	20	00	Reis	terstown	7 /MI). Z.	1136	
	Sta		31. Date filed (Month, Day, Year)	2. Registr											

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ORIGINAL

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Y	Physici /Medic	cal	Decedent's Name (First, Middle, Baby Girl Ho 4a. Facility Name (If not institution.)	Lmon	er)		4b. Citv.	Town, or I	Location of	f Death	2. Date of De Month FEBR	UAR	Year Year Year Year Year Year Year Year	2009	Time of Death	1
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£15.	Funeral Director		infant	6. Sex 1 \(\text{M} \) 2 \(\overline{\text{X}} \) F	. Age (In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	Hours 1	Min. 13	8. Date of Bii (Month, Da Feb 12			Birthplace Country) [ary1	(State or Foreign	7
	land low		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d.	Inside City Limits	3
	e Man 3a-f sh ified a	Director	MD	altimo	ore					1X Yes 2 No						
	n with th	al Dire	10e. Street and Number 4009 White Ave	nue #B2	B2 10f. Zip-Code 21206							10g. Citizen of What Country? USA				
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	ent Ever in U.S. es? No es:	S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2X No Specify:							14. Race - American Indian, Black, White, etc. Specify: black				
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Maryland	d be fi ental H ced ot l	To Be	Floyd Jones									s, maideir	ourname)			
ary	2 shoul and Mi is marl aumati		19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailir	ng Address	s (Street a	nd Numbe	er or Rura	l Route Numb	er, City or	Town, State	, Zip Coa	fe)	
Σ *	1 and 2 Health a em 27 i		The Johns Hopki	ns Hospita					Str		Baltim			1287		
nore	ages 1 ent of F t: If Ite y or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 📉 Other - Spa		ate cer	ace of Dispo metery, crer	natory or o	ne or ther place)	Di	ate	20c. Loc	ation - City	or lown, :	State	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signatur of Europa 1 do S	//-	rector		Name ar ate 7				655 W.	Bal	timore	Str	eet	
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928	e Xs e	ledic		d												_
D. Box 68	The law requires that the death certifical te has been signed by the attending phy page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown									3d. Date of o	Date of delivery Month Day Year			
ds, P.O.	w requires that the des been signed by the at should be detached f	þ	Part II. Other significant condition	ns contributing to dea	ith but not resul	ting in the t	/	_			23e. Did				ause of death?	
Records,	w requ	Completed	PREMATURE RUPIURE OF MEMBRANES								24a. Was		24b. Were	autopsy f	findings available	
8	The law ate has by page 2 s	Com									auto perfo 1 Yes	ormed? 2 No	death 1 🗌 Y	?	tion of cause of	
Vita	ysician: Tr s certificate director, pa	Be	25. Was case referred to medical examiner?	Hospital:				Other			(Check only o					_
ō	ding Physin. After this continued funeral di	ب ان	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of	Injury 2	R/Outpatien 28b. Time o		8c. Injury	at INUIT			dence 6 Other (Specify) how injury occurred				
Sion	ending sath. or: After the fune	atio	1 Natural 5 Pending 2 Accident investige 3 Suicide 6 Could n	ation	Day Year)	Injury	М	Work?	es 2 🗆 N	10						
Division of Vital	al or Atta s after de i Directo d in by t	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	Ede. I lace of	f injury - At hom	ie, farm, stre	eet, factory	, office		2	8f. Location (Cify or Tov		Number or	Rural Ro	ute Number,	
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1	vithii To th	Me	29b. Signature and title of certifier					License					signed (Mo	,	_	
			20 Name and address of	uha appraiata il	of death //	000 / / /		RES	- 00'	D		03	112/	200	9	
			30. Name and address of person v	eam	or death (item)	zoa) (Iype,	eriiit)			600 N	orth Wo	lfe St	, Baltin	nore,	MD, 2128	7
	Sta Regista		31. Date filed (Month, Day, Year)		istrar's Signatur	1	ak)					_			<u></u>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Florwary 26 **Physician** ROSA MARIA HANNIGAN 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Keswick Multi-Care Center Baltimore n/a 8. Date of Birth Aug. 19,1923 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 217-86-6069 1 □ M **XX** 85 Ecuador Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notifled at YYYes 2□No Director Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 4416 Norwood Road 21218 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be finance and Mental H Be Enrique Guzman Laura Sanchez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If Item 27 is 4416 Norwood Road Baltimore, Maryland 21218 Richard Hannigan (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If Ite
any Injury or ot 1 ☐ Burial 2X1Cremation 3 ☐ Removal from State Greenmount Crematory: 2-28-09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Euneral Service 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. (Next 1) 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician 6 weeks resulting in death) /Medical Due to (or as a consequence of): anteru Examine stickary Hyears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed and Due to (or as a consequence of): physician Physician/Medical the as attending | | for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregrant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9☐ Unknown 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bioprosthetic agrice halve replacement 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 certificate 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Beath (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification: To this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? After 5 Pending investigation 1 Vilatural Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide filled in 29a. Certifier 1 [Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division or Vital Records, P.O. Box 68760 or Attending hours after death. fo the within 24 hour.
the Funeral D

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) State Registrar

(Check only one)

29b. Signature and title of certifier

29c. License number D13657

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TISTET, BALTMARE, TO 21211

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** 20was 2009 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth Month, Day, Year 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (in yrs. last birthday) **Funeral** Days Min Vear Months Hours 1□M 2▼F Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Director nore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race 12 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 Never Married 2 Mamied Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 □ Divorced Slac 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Ke Ó 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) Be 2 19a. Informant's Name/Relationship (Type. Print) (daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 DRemoval from State 2009 = 5 Important: If any Injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name an Address of Facility
105eph L. RUSS
2272 W. North Funeral Home, Ave. Barto. Md. Approximate Interval Between Onset and Death 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Physician hen sclerotic Cercles vertenlor ulmore /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to (or as a consequence of): Examiner that the death certificate be executed burial-trar Due to (or as a consequence of) physician at the burial Box 68760, Physician/Medical attending p as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached i P.O. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 4 Unknown 2 No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has al director, page 2 s 2 No 2 No 1 Yes Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 ☐ Yes 2 ER/Outpatient 3 □ DOA 1 Inpatient funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manual of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident death 24 hours after death e Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Lock Faves

and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 1700 W. 40 th Street, Baltinure, Mazizil

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MISABELLE

31. Date filed (Month, Day, Year)

TACTRETIOR

2. Registrar's Signature

			for State Registrar	State	of Maryland		ertment of Tificate of		•	^ ^	009	ne II.
			Decedent's Name (First, Midd	lle, Last)				Douin	2. Date of Dea		100	3. Time of Death
	hysici		James W. Holdw						Month Februar	Day	Year	12:15 AM ^M
· · · · · · · · · · · · · · · · · · ·	/Medic xamin		4a. Facility Name (If not institution		umber)		4b. City, Town,	or Location of Deat		4c. County		12.13 ALI
			2921 Monocacy	Bottom Ro	oad		Adams	town		Fred	erick	c
Fu	neral		5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days		8. Date of Birt	h	9. Birthp	lace (State or Foreign
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pur	>		Usual Residence of Decedent 10a, State 10b. County	,	100 City	Town or Loc	nation					
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aryiand < 1 < 1 > - UU30 Should be filed within 72 hours after death with the Maryland and Mental Hygiene.	item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mudical Experiment nast be notified at		1 □ Never Married 2 🗓 Mar	Armed F rried 1 □Yes	orces? 2 T No	11	Yes, specify Cub	oan, Mexican, Puer	to Rican, etc.)	Blac	k, White, e	etc.
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Dallino permit. Pages Department of	ortar Injur				6.6	22	Name and Addre	ess of Facility				
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the hin 2	mplet	Medi	0.107	and mar	iner stated.							
Ь. 돌	8 8	=	29b. Signature and title of certific	Epo- 1	- mn		29c. Licens	se number	2	9d. Date signed	(Month, D	Pay, Year)
			1 Darle	Mini	1		1	21/01		2/10	1200	0/
10	J		30. Name and address of person	who completed cau	se of death (Item 23	3a) (Type, P	rint)	WT# 57	FARL	FOSTE	MA	2/701
	Stai	e	31. Date filed (Month, Day, Year)	32. [gistrar's Signature	9	1 4000	, , , , , , , ,	1	7		- , , , ,
R	egistra	_	30. Name and address of person 31. Date filed (Month, Day, Year)	7 2009	nous A	1	a del					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Fisherons Year JOYCE MARIE HESS 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hours Min 1 □ M 2 🔀 F Months Days June 13, 213-38-9788 1941 Maryland 67 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3316 Charles Street 21047 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mack (nmn) Dixon Dorothy Mable Henderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert C. Hess / Husband 3316 Charles Street, Fallston, MD 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Gdn 3-2-09 Fallston, Maryland of Fundral Saryice Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nemartha Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events BETELLO Due to (or as a consequence of): Rheuman resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 41 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed. 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1∐Yes 2**V** No Other: M Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mayrier of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed the burial-tran and P.O. Box 68760, attending physician for use as the burial signed by the at the detached for Division of Vital Records, has page 2 certificate or Attending Physician: director, this Director: After thi death. completely filled in by the Hospital within 24 hours

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Certification: To

Medical

State Registrar

Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Midical Examiner must be notified at

item 2

Department of Important: If it any Injury or conce.

Physician

/Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or Items 23a or it

Baltimore, Maryland 21215-0036

3 Suicide 4 Homicide

(Check only one)

29a. Certifier

6 Could not be determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

UNION

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mi

and manner stated

ont opner VI

PALICE 31. Date filed (Month, Day, Year)

Registrar's Signature

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Year 45PM OSHUA WILLIAM TEFFRIES 24 2009 /Medical FEBRUARY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE PEHBILITATION EXTENDED CARE BALTIMORE Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 5/7/1927 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours Year) 214-24-2031 81 Director Maryland Usual Residence of Decedent 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other than mit in the Mydferl Experiment must be notified at many injury or other traumatic event, the Mydferl Experiment must be notified at 10b County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4220 Lynhurst Road Funeral 21222 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 127 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify: 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar Jeffries ဂ Bertha Gladfelter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jeffries / Wife 4220 Lynhurst Road, Baltimore, MD 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 2/26/2009 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of preal Service Lio nsee 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE HEART disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 PULMONARY DBSTRUCTIVE icate has been si ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy certificate 2 12 No 1 □ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Certification: To

Box 68760. P.O. I Records, Division of Vital Hospital or Attending

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

29a, Certifier (Check only one)

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

30272

2/24/2009

millen MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOCH RAVEN BOULEVARD BALTIMORE, MD. 21218 3900 THOMAS S. MILLER 31. Date filed (Month, Day, Year)

State Registrar

After this funeral c

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neral Director: Aft

filled in by the fun

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within 2

completely

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day JOHN DUNCAN JARRETT February 24,2009 9:45 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON 1 Year | If Under 24 Hrs. | BALTIMORE Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 2**15-**30-8335 Mar 1, 1934 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland | Baltimore County Lutherville 10e. Street and Number 10g. Citizen of What Country? 10 Fieldspring Court 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 57–59 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married 1 Yes 2 ☐ if Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Proprietor Property Management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin Bosley Jarrett Dorothy Duncan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ellenor B. Jarrett (Wife) 10 Fieldspring Court, Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Thomas Church Cem. 3/4/2009 Garrison. Maryland Martin D. Lawson 22. Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC. Real timore, Maryland 21212 21. Sign / ha 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) [neumoniti Due to (or as a consequence of) Due to Clu S i) (a S ti'c syndrome Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Nation 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending

Physician /Medical Examiner Examine and

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or items 23a or 28a-f show important: If them 27 is marked other than "natural", or other thanmatic event, the Medical Examiner must be notified at any injury or other thaumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

altimore,

burial-transit law requires that the death certificate be executed physician the attending for use ed by the a detached f page 2 should peen certificate

this funeral After t

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

2 State Registrar

Physician/Medical ≥ Completed ၉ Certification: thin 24 hours after death.

the Funeral Director: A pmpletely filled in by the fu Medical

31. Date filed (Month, Day,

29b. Signature and title of certifier

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

investigation 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

D20907

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 Worth C

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State	State of Maryland				Mental Hyg	iene	
			Registrar		Cei	tificate of L	Death		eg. No2 0 0 9	06149
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d 2	filed Hygir ther		17. Father's Name (First, Middle, Last)	NA		Sapy	18. Mother's Nam	ne (First, Middle, N	(1aiden Surname)	
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Maryland	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type	Print) a Candmath	19b. Mailin	g Address (Street a	and Number or Ru	ral Rote Number,	City or Town, State,	
ž	and 2 salth a 27 is		Ms. Yvette Pa	irham	200	Bedfor	d Rd#	2A WO	burn N	lA
ore	of He	1 3	20a. Method of Disposition		ace of Dispo	sition (Name of natory or other place	9)	Date 2	20c. Location - City or	Town, State
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Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mustical Event in mast be notified at once.		21. Signature of Funeral Service Licensee	m un	22	Name and Addres		ineral b	toma DA	
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M.	Physician /Medical		disease or condition resulting in death)	Premat	4117	· y				0.1001 0.100 2.001
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<u>></u>	hysic this or		1 ☐ Yes 2 📉 No	pital: 1 ☑ Inpatient 2 ☐ E			4 🗆 Nursing H	ome 5 Reside	nce 6 □Other (Spe	ecify)
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	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical Examiner one)	: On the basis of examination and manner stated.	on and/or inv	estigation, in my op	inion, death occu	rred at the time, da	ite and place, and due	e to the cause(s)
	Veith To the community	Σ	29b. Signature and litle of certifier	Λ		29c. License			d. Date signed (Mont	
			fle ton	4-			9039	F	-ebruan	26,2809
			30. Name and address of person who comp	leted cause of death (Item	23a) (Type, F	Print)	7		7	
نو	Sta	to.	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire Corre	en St	Baitin	wre, m	1) 212	0/
	Registra		EED 2 7 200		6 4	-41				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** JAMERSON GERALINE 25, 2009 EBR4AR /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BON SE COURS HOSPITAL BALTI MORE 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 🛠 🗆 F Months Days Hours 83 04 16 MD Director 577-60-5513 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County show th and Mental Hyglene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1√2 Yes 2 □ No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21216 1221 North Bentalou Street Funeral be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes X ☐ No Specify. Specify: Black ğ 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Dept. of Defense 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Greenberry Riggs Annie L. Sheary Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 North Bentalou Street, Baltimore 21216 Michael Yancey-Son Health a permit. Pages 1 and Department of Health Important: If item 27 any injury or other tonce. or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 3/2/09 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANCER TO THE **Physician** /Medical Due to (or as a consequence of) Examiner ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ful to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ cate has been signal page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 No 2 1. No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 → No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

Saltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day,

and manner stated.

cause of wath (Item 23a) (Type, Print)

29a. Certifier

29b. Signature and title of certifie

Medical

1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00030355

BON SECOURS HOSPITAL

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		•	rtificate of		R	eg. No. 20	09	06151
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day	Year	3. Time of Death
٠,	/Medic	al	Arthur Wil 4a. Facility Name (If not institution, give s	liam Jones,	Sr.	4h City Town o	r Location of Death	Februar	y 20, 2		10:40A ^M
	Examin	er	The Tate House	treet and number)		Lintl				e Aru	ındel
_	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birthpla	ace (State or Foreign
١	Director		214-28-4578 Usual Residence of Decedent	^{] M 2□ F} 78	Yrs.	Months Days	Hours Min.	Nov 9,	1930	Mary	yland
	ow ow		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10	d. Inside City Limits
	Mary Inch	to	Maryland Anne Aru	nde1	Sex	vern					1 □Yes 2 🔀 No
	or 28g	Director	10e. Street and Number			10f. Zip Code	_	1	0g. Citizen of W	hat Count	ry?
	th wit		8561 Pioneer Driv	e		2114	44		Unit	ed St	tates
	ems er m	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Dican, etc.)		- America	
20	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23a or 28a-f show other than "hadical Evanirer must be retified at event, the Medical Evanirer must be retified at	by Fu	1 Never Married 2 Married	1 ∐Yes 2 📉 No If Yes. Give		1 □Yes 2X No	Specify:		Specify:		
5-0036	hours tural	q pa	3 ₩ Widowed 4 Divorced	Year or Dates:	16a Dece	edent's Usual Occup	ation		16b. Kind of But		ustry
Ċ	in 72 n "na"	plet	15. Decedent's Educ (Specify only highest grade		(Give	kind of work done of DO NOT use retired	during most of work	king			,
717	with giene. r thai	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Br	ick Layer	r		Mas	onry	
_	0 = 0 %	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, M	Maiden Surname	9)	
yıand	2 should be and Menta is marked aumatic ev	၉	Landy Jones		,		Glad	ys Sm	ith		
Mar	2 sho and is ma		19a. Informant's Name/Relationship (Ty)			ng Address (Street			-		
<u>~</u> `	and lealth m 27 her tr		Rita Lee Lynch/dau			Pioneer 1		vern, Ma	ryland 20c. Location - 0		
baltimore,	ges 1 If ite or ot		20a. Method of Disposition 1	emoval from State		osition <i>(Name</i> of matory or other plac	i i			•	
	it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (Specify)			Cemeter					Maryland
pa	permit. Pages 1 and 2 should be Department of Health and Mentis Important: If item 2 is marked any injury or other traumatic e once.		21. Signature of Funeral Service License	To the second of) 1957 1	^{2. Name and Addre} Oonaldson [411 Anna _]	°Funeral polis Roa	Home & C d Odent	remator on, Mar	y, P.	.A. d 21113
П			23a. Part1 Enter the disease, or compli- shock or heart failure. List only on	cations that caused the deat	h. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between
*	Physician		Immediate Cause (Final disease or condition	Cece	7:01	J95 C4/	9 C Di.	FRACE			Onset and Death
and the	/Medical		resulting in death)	Due to (or as a conseq							
Н	Examiner	_	Sequentially list conditions, b								
	N E	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	juence ot):						
	al-trar	xar	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	uence of):						
6876U,	e be e siciar burie	Sal									
200	tificat g phy as the	Nedical									
X D	h cerr endin use a	In/M	23b. was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		☐ Ectopic pregnanc				of deliver	•
<u>.</u>	deat he att	Physician/	in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnant at time of c		Other (specify)	, 		Mor	nth [Day Year
7	at the	Phy	9 Unknown				an in Cont I	220 Did tob	agge use contri	bute to the	e cause of death?
Š,	res th	þ	Part II. Other significant conditions con	tributing to death but not resi	uiting in the u	inderlying cause giv	en in Part I.		s 2 No		\.
cords,	requi	Completed									7
9	e law has t je 2 s	mple						24a. Was ai	y p	/ere autop rior to com eath?	sy findings available npletion of cause of
_ 	n: Th ficate r, pag							perform 1 □Yes 2			2 No
VII	sicial certi recto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐	1 FD (0. 44)-	oth Oth		th <i>(Check only on</i> ome 5 ☐ Reside		1100	Dice .
0	y Phy er this eral d	J: To	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time o			28d. Describe ho			110015-
5	nding tth. r: Afte e fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury		k? Yes 2 □No				
VISION	r Atte er deg recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, sti	reet, factory, office		28f. Location (St. City or Town	reet and Numbe	er or Rural	Route Number,
5	oital or urs aft ral Di										
	To the Hospital or Attending Physician: The law requires that the death certificate be excepted within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		sician: To the best of my kno ner: On the basis of examina and manner stated.							
	To th within To the comp	Me	29b. Signature and title of certifier	100-		29c. Licens	e number	2:	9d. Date signed	(Month, E	Jay, Year)
			Junich	K, KRZ	3	5	3155	1 7	-e hru	Circi	20 2019
	2		30. Name and address of person who co	mpleted cause of death (Iten	n 23a) (Type,	Print)	1	()	0	1	1
			Jussell 2,00	Luca, D	303	H0501	tal Ds	NP, C/P	Dr. Chi	1.12	.2100
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	ed "					

Registrar

		1 - State State Registrar	of Maryland / Dep	oartment of Fertificate of			ene g. No. 2009	0615
Physici /Medic		1. Decedent's Name (First, Middle, Last) Jerome Dewey J	iggetts			2. Date of Death Month	Day Year	3. Time of Death Z100 M
Examin		4a. Facility Name (If not institution, give street and Season's Hospice 5. Social Security Number 6. Sex	number) 7. Age (In yrs. last birthda	Rand	or Location of Death allstowr If Under 24 Hrs.		4c. County of Death Baltimo	
Funeral Director		103-38-4907	63 Yrs.	Months Days	Hours Min.	(Month, Day, 12/03/19	945 Cou	VA
the Marylar 28a-f show	Director	10a. State 10b. County MD 10e. Street and Number	10c. City, Town or	Balti:	more	10	g. Citizen of What Cou	10d. Inside City Limits 1 □ Yes 2 □ No
23a or		1626 Normal Avenue		101. Zip 00d0	21213		USA	
IOFE, INICITYICATION ZIZIO-UUSO ges 1 and 2 should be filed within 72 hours after death with the Maryland ti of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Midnal Even than mutility and the	by Funeral	1 Never Married 2 Married 1 Yes.	Forces?	8. Was Decedent of H If Yes, specify Cub 1 □ Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: B]	
C Z IZIO-0030 filed within 72 hours aft Hygiene. wither than "natural", or ent, the "Medical Evernant, the Medical Evernant	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College 12	ed) i (Gir	cedent's Usual Occup ve kind of work done DO NOT use retire Taxi Dri	during most of work d)	ing	6b. Kind of Business/Ir Fransporta t	·
INICAL VICENTICA CAS Should be filed to the and Mental Hygin is Tis marked other traumatic event, the contractions of the cont	To Be C	17. Father's Name (First, Middle, Last) unknown				e (First, Middle, Mi McCuthen	 	
e, Marly 1 and 2 sho Health and I em 27 Is ma			Wife 162	26 Normal	Avenue, B	altimore	City or Town, State, Zi , MD 21213	
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	Garc	ematory of other plac on Memory lens	^(ce) 2/28	/2009 ₁	Oc. Location - City or To	
Dalill permit. Departr Importa any Inji		21. Signature of Funeral Service Licensee Dor	un suali	1501 East	. FOLL AVE	nue, bar	Home Inc. timore, MD	21230 Approximate
Physician //Medical Examiner bhysician and stree private priv	dical Examiner	Sequentially list conditions, if any, leading to immediate dauge. Enter Underlying Cause (Disease or injury that initiated events	to (or as a consequence of): to (or as a consequence of): to (or as a consequence of):	ON CAN	CER			Onset and Death
he death certi the attending	Physician/Medi	in the past 12 months?		B ☐ Ectopic pregnand I ☐ Other (specify) _	cy		23d. Date of deliv	ery Day Year
quires that the signed by all do detact	ρ	Part II. Other significant conditions contributing to	o death but not resulting in the	underlying cause giv	ven in Part I.		acco use contribute to t s 2 ☐ No 3 ☐ Pro	
VILCI INCUIUS, sician: The law requires the contificate has been signe	Completed				·		ed? death? ☑No 1 ☐ Yes	opsy findings available impletion of cause of
Physician: Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1	☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Oth		h <i>(Check only one)</i> ome 5 ☐ Resider) nce 6 ☑ Other (Speci	ONS HOSPICE
ending ath. or: After	Certification:	1 Natural 5 Pending (N 2 Accident investigation 3 Sylvide 6 Could not be	ate of Injury 28b. Time fonth, Day, Year) Injury	M 1	ry at k?]Yes 2 □ No	28d. Describe hov	v injury occurred	
To the Hospital or Attending within 24 hours after death or To the Funeral Director: After completely filled in by the fune		4 Homicide determined	ace of Injury - At home, farm, silding, etc. (Specify)			City or Town,		
he Hosi n 24 ho e Fune pletely f	Medical	29a. Certifier (Check only one) 1 N Certifying Physician: To 2 Medical Examiner: On the and m						
Total within Total Comp	Ř	29b. Signature and title of certifier **LulluleBulur**		29c. Licens			d. Date signed (Month, Fobruary 2	
6		30. Name and address of person who completed o	ause of death (Item 23a) (Type 28 35)	on Print) Smith Au	enue Sul	te 203 6	February z Baltimone	POSISON
Sta Registr	- 3	31. Date filed (Month, Day, Year) 37	Rėgistrar's Signature	well				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Gracie Antionette Johnson February 23, 2009 3:18 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Civista Medical Center La Plata Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. 60 Virginia Director 226-72-3948 21, 1948 Aug. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Experiest must be notified at 10d. Inside City Limits Director 1 ☐Yes 2 No King George King George VA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14282 Chastine Drive Funeral 22485 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. þ Specify: Black 3 ☐ Widowed 4 😾 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian 12 Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Bernard David Allen Flossie E. Campbell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoine Hyman - Son 14282 Chastine Dr., King George, VA 20b. Place of Disposition (Name of cemetery crematory or other place)
Salem Baptist
Church Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-28-09 King George, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bailey Funeral Service 1207 White St., Fredericksburg, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 1 schenx disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter third-right Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed cate has by page 2 sl 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Physician: The certificate Division of Vital 1 □Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural n 24 hours after death.

e Funeral Director: Aff
letely filled in by the fun 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D005883 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25500 po I Loo kout vd 120m town MD 3050 Tagour. MD MA. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #18 per Fh g889 3/17/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year М JOHNSON. **FEBRUARY** 21, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 X M 2 □ F Yrs. 429-60-5688 NOV. 12, 1934 AR Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No PRINCE GEORGE'S TEMPLE HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4301 23RD PKWY #513 20748 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🕅 No Specify: 3 ₩ Widowed 4 □ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STATISTICIAN US CENSUS BUREAU 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ZACK JOHNSON, SR. MARY UNK Sims 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHERYL JOHNSON / DAUGHTER 10400 RAMBLING HILL CT UPPER MARLBORO, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) METROPOLITAN CREMATORY 02-26-2009 ALEXANDRIA, VA 21. Signatur of Funeral Service 22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD DONALD R. GRAY 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part J. Enter the dis-shock or heart failu Immediate Cause (Final Enter the disease applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. L Carcinin 1100066 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Myounded Interesto M 1 331 W Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown

Physician) /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

the

with 1

death

Pages 1 and 2 should be filed within 72 hours after anent of Health and Mental Hygiene.
The filed To Is marked other than "natural", or lite and the traumatic event, It was a file to the traumatic event.

permit. Pages 1 Department of H Important: If ite any Injury or ot

Baltimore, Maryland 21215-0036

ral", or Items 23a or 28a-f shov Examination religion at

Director

by Funeral

Completed

Be

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Examiner anding physician and use as the burial-transit signed by the a È has been s e 2 should his certificate ha B To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

Physician/Medical IF FEMALE Medical Certification: To

Part II. Other significant conditions co	ontributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacci 1 ☐ Yes	o use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 🎇 Unknow
				24a. Was an autopsy performed?	
25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
1 Yes 2 MNO	Hospital: 1 X Inpatient 2 □] ER/Outpatient 3 ☐ !	OOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Specify)
27. Manner of Death 1 X Natural 2 Accident 5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory)	ory, office	28f. Location (Street and City or Town, Sta	and Number or Rural Route Number, ite)
29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and pla on, in my opinion, death oc	ce, and due to the cause curred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier		.2	9c. License number	29d F	Pate signed (Month, Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hom in

503 Medona

31. Date filed (Month, Day, Year) FER 2 7 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Physician LHBY RSE ZUISWY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner wesminster arre! 2001 cente 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days 1 M 2 □ F 6,1947 Maryland 61 **Director** 214-46-7373 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ns 23a or 28a-f show 1 ☐ Yes 2 No Funeral Director Union Bridge Frederick MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 11720 Beaver Dam Road 21791 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ō 1 ☐Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Board of Education maintenance 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) f Health and Mental F tem 27 is marked otl Mary R. Morningstar Charles I. Joy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11720 Beaver Dam Rd. Union Bridge, Md 21791 Department of Health Important: If item 27 any Injury or other tr Linda L. Joy/wife 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/26/09 Union Bridge Md. Beaver Dam Cem. 22. Name and Address of Facility Hartzler Funeral Home P.A. 21. Signature of Funeral Service Licensee 11802 Liberty Rd. Libertytown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronar WEKS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760; Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a. Certifier t 🛮 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 357 295 Mysel Ms onn (32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For Amend Item 24ta - State Registrar	teper Maryland go	ക്കു ത്തുമു † Certificate	of Deat	h and Men h	tal Hygie Reg.		06156
			1. Decedent's Name (First, Middle, Last)				2. [Date of Death	C U U J	3. Time of Death
	Physici /Medic		Robert Jones				Fé	yonth bruary	18, 2009	1:50 PM M
1	Examin		4a. Facility Name (If not institution, give street a			wn, or Location	on of Death		4c. County of Death	
-1			Joseph Richey Hospic			imore	04 Um 0 =		1 0 8: 0	
ı	Funeral Director		5. Social Security Number 218–42–9099 6. Sex 1 ☑ M 2	7. Age (In yrs. last bit	Yrs. If Under 1 Months C	ays Hour	der 24 Hrs. 8. E rs Min. Ma	Date of Birth Month, Day, Ye y 3, 19	9. Birthi Cour Mary	place (State or Foreign atry) Land
	pu »	1	Usual Residence of Decedent 10a. State 10b. County	10c, City, Tow	n or Location				1	0d. Inside City Limits
	f sho	9	MD		timore					1√ Yes 2 No
	28a-	Director	10e. Street and Number	Dai	10f. Zip C	ode		10g.	. Citizen of What Cour	ntry?
	3a or	Ö	2457 Druid Hill Avenu	ıe	2	1217			USA	
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examinar must be redified at	by Funeral	1 Never Married 2 Married 1 If Y	s Decedent Ever in U.S. ned Forces?]Yes 2 [A]No es, Give ar or Dates:	13. Was Deceder If Yes, specify 1 □ Yes 2 X	Cuban, Mexi	ican, Puerto Rica	Yes or No- n, etc.)	14. Race - Americ Black, White, Specify: bla	etc.
9	2 hou	ted	15. Decedent's Education		Decedent's Usual ((Give kind of work)	Occupation	nost of working	168	o. Kind of Business/In	dustry
218	I within 72 ho giene. r than "natui the Medical	Completed	(Specify only highest grade comp	llege (1-4or 5+)	life. DO NOT use	retired)	nost of working			
21	filed wit Hygien other the	ပ္ပ		0	labor	4 - 1			constructi	.on
Maryland	e d dal	To Be	17. Father's Name (First, Middle, Last)		un	.K 18. Mc	other's Name <i>(Fir</i> Lillian			
Mary	12 sho th and 7 is m traum		19a. Informant's Name/Relationship (Type. Pri Lillian Coleman/moth		o. Mailing Address (S B51 Edgeco	treet and Nur mb Cir	mber or Rural Ro cle Sout	oute Number, C th Balt	ity or Town, State, Zip imore, MD	21215
Baltimore,	- I = 5		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 █ Other (Specify) in	I from State cemete	of Disposition (Name ery, crematory or othe	of er place)	Date	200	c. Location - City or To	own, State
Balt	permit, Pages Department of Important: If i any Injury or once.		21. Signature of Euneral Service licensee Ronald S. Wade	Director	State Ar Baltimor	-	Board 6.	55 W. B	altimore S	Street
			a. Part Enter the disease, or complication shock, heart failure. List only one cau	s that caused the death. Do				spiratory arrest	,	Approximate Interval Between
-	Physician				a Her a	deine	1 meta	Heres		Onset and Death
	/Medical		resulting in death)	ver carciamoue to (or as a consequence	of):	. 1		140		
	Examiner		Saussifiativ list conditions			tection				
	ed sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	of);					
_	xecut and Il-tran	Examin	that initiated events c	Due to (or as a consequence	of):					
58760,	icate be executed physician and the burial-transit	E E	d	,	,					
687		edical	d							
O. Box	Pnysician: The law requires that the disath certific this certificate has been signed by the attending priral director, page 2 should be detached for use as	Physician/Me	in the past 12 months?	res, outcome of pregnancy ☐ Live birth 2 ☐ Fetal deat ☐ Pregnant at time of death ☐ Unknown	h 3 Ectopic pre				23d. Date of deliv Month	rery Day Year
σ.	that the ed by detac		Part II. Other significant conditions contributi	ng to death but not resulting	in the underlying cau	se given in Pa	art I.	23e. Did tobac	cco use contribute to	the cause of death?
Records,	uires that n signed I	Completed by	COPO Alcoholar -	Tobacco Smol	FIM			1 ☐ Yes	2 No 3 Pro	bably 4 V Unknown
00	w requir	lete	,		0			24a. Was an	24b. Were auto	opsy findings available
Be	The law	E G						autopsy	d? death?	ompletion of cause of 2 No
of Vital	sician: Th certificate rector, pag	Be C	25. Was case referred to medical		·-··	26. P	lace of Death (Ci	1 ☐Yes 2 X heck only one)	JNo 1 □Yes	2 🗆 140
>	ysici is cer direct		examiner? 1 ☐ Yes 2 ☑ No Hospita	ıl: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA	Other: 4	Nursing Home	5 Residence	ce 6 ☑Other (Spec	ly) Hargice
0	ding Ph h. After th funeral	L:u	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	a. Date of Injury (Month, Day, Year) 28b.	Time of 280	. Injury at Work?	28d.	Describe how	injury occurred	
<u></u>	endir eath. or: A he fu	atic	2 Accident investigation		M	1 ☐ Yes 2	2 □No			
Division	al or Att	Certification: To	3 Suicide 6 Could not be 4 Homicide determined 28	e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory, o	office	28f.	Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical ((Check only 2 Medical Examiner: C	To the best of my knowledge the basis of examination and manner stated.						
	Vithir vithir comp	Me	29b. Signature and title of certifier		29c.	License numb	per		. Date signed (Month	
			MYWWV	A-D	74	1476	(wai)	(52.18.200	9
			30. Name and address of person who completed RAYMOND W. WYLON M.D.	ad cause of death (Item 23a	(Type, Print)	416 7	Balt impre	MD 2	4051	
	St	ate	31. Date filed (Month, Day, Year)	32/Registrar's Signature	1					
	Regist	rar	FEB 2 7 2009	32/Registrar's Signature	gare					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Baby Boy Kalombo Rbruary /Medical nty of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death loseda last birthday If Under 1 Year If Under Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ★ M 2 🗆 F Yrs Director Feb 18, infant 2009 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No Director Baltimore Rosedale the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with o a items 23a (iner must b 6227 Commons Road Funeral 21237 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 XNever Married 2 Married "natural", or 1 ☐ Yes 2 No Specify. þ Specify: black 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) infant infant nd 2 should be filed wath and Mental Hygier 27 is marked other the traumatic event, the infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sean Crowley မ Antho Kalombo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is 9000 Franklin Square Drive Rosedale, MD Franklin Square Hospital 21237 or other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other(Specify) in state 21. Signature of Funeral Support 22. Name and Address of Facility Wade State Anatomy Board 655 W. Baltimore Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner horioamnioniti Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical attending properties of the second IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 🕱 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 No Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No Certification: To 1 Tyes 1 🗖 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury al Director; 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0

Division or Vital Records, P.O. Box 68760, within 24 hours a To the Funeral I Hospital

2

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** February 20, 2009 Larry R. Kline 1128 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 201 Park Circle Elkton Ceci1 8. Date of Birth (Month, Day, Year) Sept 22, 1 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☑ M 2 □ F 73 Ĩ935 **Director** Maryland 215-32-5981 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 □Yes 2√□No MD Cecil Elkton 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? 201 Park Circle 21921 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 Is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 mail carrier postal system 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon Cooper Kline Majorie Elisabeth Rhodes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau Emma Lou Kline/spouse 201 Park Circle Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Dicerse Wade, Dicertor State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part 1 Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cau (Final disease or condition resulting in death) **Physician** 2-Loceks /Medical e to (or as a consequence of Examiner Sequentially list conditions, Dise to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ∐ Yes 2 340 director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۴ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: / 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

			For State	State of M	laryland				d Mental Hy	0	000	0015	- 0
			Registrar 1. Decedent's Name (First, Midd	le, Last)		Cei	rtificate of I	Death	2. Date of De	Reg. No.	009	3. Time of Death) 9
	Physic /Medi			Sik Kim					Month Febru	Day	Ye <i>a</i> r 2009	2:30 P.	
78	Exami		4a. Facility Name (If not institution Gilchrist H)		4b. City, Town, or TOWSO		eath		ty of Death		
	Funeral		5. Social Security Number 219-90-8368	6. Sex 7. A	ge (In yrs. last		If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bir Min. (Month, Da	rth ay, Year)	9. Birthpl	ace (State or Fore	ign
	Director		Usual Residence of Decedent	1010122	83	Yrs.			2/6/	1926		, Korea	
	aryland show	_	10a. State 10b. County		10c. City, T						10	d. Inside City Lim	
	the Mi	recto	Maryland Balt	imore		Sparl	10f. Zip Code			10g. Citizen of	f What Count	1 □ Yes 2,□ (,10
	23a or	ral Di	2 Apt. H Shel	bys Path			2115	2		Unite	d Stat	es	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Mudical Evantinal must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mai 3 ☑ Widowed 4 □ Divorced	If Yes Give	?		Vas Decedent of H f Yes, specify Cuba □ Yes 2 □ No	ispanic Origin n, Mexican, Pi Specify:	? (Specify Yes or No uerto Rican, etc.)		ace - America ack, White, e ify: KOL	tc.	
15-0	n 72 ho "natui	letec	(Specify only highe	nt's Education st grade completed)	1	I6a. Deced	lent's Usual Occupa kind of work done of OO NOT use retired	ation furing most of	working	16b. Kind of I	Business/Ind	ustry	
2121	d within giene. er than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		emaker)		Own :	Home		
Maryland	uld be file Mental Hy arked othe	To Be (17. Father's Name (First, Middle, Ji SOC						Name <i>(First, Middle</i> BON KIM	Maiden Surna	me)		
	and 2 sho salth and n 27 Is ma	1 2	19a. Informant's Name/Relations Mr. Kwi Sung K		1				Rural Route Numb Baltinore				
Baltimore,	Pages 1 and the He ant: If iten ant: If iten ary or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		ceme	etery, cřem	sition (Name of hatory or other place Valley Gardens		Date Druary 2009	20c. Location	•		
Balt	permit. Departi Importi any inji		21. Signature of Funeral Service	Licensee	, ren	22 ea	Name and Address CCTUL AL 2325 Yor	s of Facility ternat k Road	ives Fune Timoniu				• À
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. My de Due to (or as b. 15 C H 2 Due to (or as c. D 1 A C	ne.	ce of):	er the mode of dyin			rrest,		Approximate interval Between Onset and Death SAMS	<u> </u>
P.O. Box 68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	of pregnancy	ath 3 🗆	Ectopic pregnancy Other (specify)				ate of deliver	y Day Year	
rds, F	w requires that been signed I should be det	þ	Part II. Other significant condition CHRONIC KI			g in the un	derlying cause give	n in Part I.	23e. Did t			cause of death?	vn
of Vital Records,	i c ian: The law re certificate has ber ector, page 2 sho	Completed	25. Was case referred to medical						1 □Yes	rmed? 2 DNo	Were autopoprior to comdeath?	sy findings availab pletion of cause o	le f
f Vi	hysician: this certific al director,	To Be	examiner?	Hospital: 1 ☐ Inpatie	ent 2 ☐ ER/	Outpatient	3 ☐ DOA Othe	r:	Death <i>(Check only o</i> g Home 5 ☐ Resid		her (Specify)	HOSPICE	
o uc	ding Afte fune	ion:	27. Manner of Death 1 Anatural 5 Pendin			b. Time of Injury	28c. Injury Work'	at ?	28d. Describe t			11-0-6-0	
Division	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Certification:	2 Accident investig 3 Suicide 6 Could 4 Homicide determ	not be 28e Place of Ini	ury - At home, c. (Specify)	, farm, stre		′es 2□No	28f. Location (S City or Tox	Street and Num in, State)	ber or Rural i	Route Number,	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifyir 2 Medical	g Physician: To the best Examiner: On the basis o and manner str	f examination	dge, death and/or inv	occurred at the timestigation, in my op	e, date and plainion, death o	ace, and due to the ccurred at the time,	cause(s) and m	nanner as sta	ited. he cause(s)	
	To the within 2 To the complet	2	29b. Signature and title of certifie				29c. License	number		29d. Date signe	ed (Month, D	ay, Year)	\dashv
					17		26	14395	5 /	EBRUAT	24 26.	2009	
	3 1		30. Name and address of person DANIEUF DORF	who completed cause of d	eath (Item 23	a) (Type, P	rint)	4/17 20	4 RAI 77	ment. 1	10 21	204	
	Sta Registr	te ar	30. Name and address of person DANIEUT DOBET 31. Date filed (Month, Day, Year)	2009 32. legistra	ar's Signature	pa	wed		1 01141			/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 – For State Registrar	State of Ma	ryland		artment of I rtificate of			,	-	2000	0010	
			Hegistrar Name (First, Middle, Included)	Last)			lineate o.	Dean,		2. Date of De		000	3. Time of Death	L
	Physici /Medic		Francis Cheste	r Kasprzak					E	Month February	20	2009	9:50 A M	1
	Examin		4a. Facility Name (If not institution,	,			4b. City, Town, o		of Death		1	unty of Death		
435			1285 Bartonshire 5. Social Security Number 6		(In ure In	ast birthday)	Rockvil If Under 1 Year		24 Hrs	8. Date of Bir		gomery		_
	Funeral Director		145-24-2809	1 X M 2□ F	78	Yrs.	Months Days	Hours	Min.	(Month, Da	ay, <i>Year</i>)	Cou	place (State or Foreig ntry) Jersey	n
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits	
	Maryli -f sho lied at	tor	Maryland Montgo	m 0 M I								'	1 □ Yes 2 No	
	or 28a	irec	10e. Street and Number	mery	KO	ckvill	10f. Zip Code				10g. Citizer	of What Cour	ntry?	_
	ath wit	ral	1285 Bartonshire	Way			20854				United	l State	es.	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. It is Health and Mental Hygiene. or items 23a or 28a-f show or other traumatic event, the Maralcal Exp. ill act must be notified at or other traumatic event, the Maralcal Exp. ill act must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ∑Yes 2 □ N If Yes, Give Year or Dates: 1	0		Vas Decedent of H fYes, specify Cub □Yes 2X No			cify Yes or No Rican, etc.)		Race - Americ Black, White, ecify:	etc.	
21215-0036	72 hou natura ical E		15. Decedent's	Education	932-1	16a, Deced	lent's Usual Occup	pation			16b. Kind	of Business/In		_
121	within 7 jene. r than "r r e M	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5-	-)		kind of work done OO NOT use retire		st of workin	1				
	filed w Hygie other t	o) ∈	17. Father's Name (First, Middle, La	4 st)		Proje	ct Engin		er's Name	(First, Middle,			evelopment	_
<u>lan</u>	should be filed within and Mental Hygiene. s marked other than " umatic event, It e Me	To Be	Francis Kasprz	,						ne Maz		name		
lary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street					wn, State, Zip	Code)	
e, ≥	1 and Health em 27 ther tr		Joan C. Kasprzak	/Wife	not pi		Bartonsh	ire Wa	_			_ <u>-</u>		
Baltimore, Maryland	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		Mon	metery, crem t gomer	sition (Name of natory or other place 'V	ce)	Febru 25, 2	ate lary		on - City or To	•	
altir	mit. P partme sortan / Injur		4 ☐ Donation 5 ☐ Other (Special Service Lice 1)		Crem	natori	um Inc Name and Addre	ss of Facilit	25, 2	.009 : -	Bethes	da, Ma	ryland	
<u>~</u>	B a E D B	: W	I And flu		M0136	50 R	obert A. 00 West Mon	Pumpl tgomery	hrey y Avena	Funera Je, Rock	l Home ville, N	:/Rockv faryland	ille, Inc. 20850-2805	. 1
Ę			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused l ly one cause on each line	he death.	Do not ente	er the mode of dyi	ng, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death	
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Pancrea			r					6	Months	
1	Examiner			Due to (or as a	conseque	ence of):								
1	pit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	conseque	ence of):								_
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68760	ificate be executed g physician and its the burial-transit			200 to (0) as a	oonooque	2110C 01).								
		Medical	IF FEMALE:		, -									
Box	death certifi ie attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o	Fetal o	death 3 🗆	Ectopic pregnanc	ey.			23d.	Date of delive	ery Day Year	
	9 9 9	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	ime of dea	ath 5∟	Other (specify) _		****			World	Day real	
ი. ლ		by Pr	Part II. Other significant conditions	contributing to death but	not result	ting in the un	derlying cause giv	en in Part I.		23e. Did to	obacco use o	contribute to the	ne cause of death?	
ord.	w requires been signe should be									1 🗆 Y	′es 2X N	o 3□ Prob	ably 4 🗌 Unknown	
Vital Records,	e law r has b e 2 sh	Completed						<u> </u>	<u></u>	24a. Was autop	sy	prior to cor	psy findings available npletion of cause of	
			25. Was cape referred to medical							1	2 X No	death? 1 ☐ Yes	2 🗆 No	
= :	ysicia is cert directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatien	t 2 X 1E	B/Outpatient	3 TI DOA Oth			(Check only or		Other (Specify		-
Division of	ng Ph fter th ineral	T:UO	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,	2	28b. Time of Injury	28c. Injur Worl			Bd. Describe h			<u>() </u>	-
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		edical (29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner state	examinatio	ledge, death on and/or inv	occurred at the tire estigation, in my o	me, date an pinion, deat	nd place, a	nd due to the d	cause(s) and date and pla	l manner as so ce, and due to	tated. the cause(s)	
i	Withi To the	Ž	29b. Signature and title of certifier	10	0.		29c. Licens	e number		- 1	29d. Date siç	gned (Month, I	Day, Year)	
		-	faul		01		D006	1083		F	ebruar	y 20,	2009	
+1			30. Name and address of person who Paul M. Thambi M					ra C	iito S	300 P-	01/27/1	1 o M = -	yland 20850	
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar	s Signatui	re		e, bu	TLE -	, KC	CKVII	re, Mai	.y1ana 2003(4
	Registra	ır	0 × 0	100	. 4	hor	Alex .							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Vear aes eh /Medical 200 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Howard County General Hospital** Columbia Howard 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 M 2 □ F Months Days Hours Min. 356-20-4939 Yrs Director 80 Apr 25, 1928 Usual Residence of Decedent 10a. State show 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at MD Director Howard Ellicott City 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3926 Hawthorn Drive 21042 U.S.A. Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No IfYès, Give Ye ar or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No ð 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) **Electrical Engineer** Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amos Kline 2 Laura Eckhardt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and Department of Health a lmportant: If item 27 is any injury or other trau Doris O. Kline 3926 Hawthorn Drive Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Deponation 5 Dother (Specify) Atlantic Crematory, LLC Feb 23, 2009 Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Mundadla rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death lediate Cause (Final **Physician** sease or condition esulting in death) iration /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s 24a. Was an has autopsy perform certificate 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATERRA ARMEN DALV 31. Date filed (Month, Day, Year) strar's Signature State Registrar

09-01595 Angela Lynch

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day February 23, 2009 2237 hrs Angela Lynch **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital Baltimore 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Months Days Director 5-29-1956 Country) 1___M 2X XF MD 52 218-62-7335 Usual Residence of Deceder 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 1XXYes 2 No 28a-f show MD N/A Baltimore permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U S 616 N. Luzerne Avenue 21205 Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 Yes 1 Yes 2XX No specify: Black If Yes, Give Year Specify: Widowed 4 X Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Disabled 21215-0036 Disabled 10th grade N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Rodgers <u>Carolyn Nixon</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B 2327 Guilford Avenue Pamela McDermott-Sister Balto, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place)
Mt Zion Cemetery 1 X Burial 2 Cremation 3 2-28-09 Lansdown, MD Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 **Physician**

/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

failure. List only one cause on e			spiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
minimum bacco (r mai diocase	 Complications of morbid obesity 			Death
or condition resulting in death)	Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):			
UNPENDED	AMENDED			
IF FEMALE:	23c. If yes, outcome of pregnancy		23d. Date of delivery	
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknow	1 Live birth 4 Pregnant at time of death 5 Unknown	Fetal death 3 Ectopic pregnancy Other (Specify)	Month C	ay Year
Part II. Other significant conditions	contributing to death but not resulting in t	he underlying cause given in Part I	23e. Did tobacco use contribute to	the cause of death?
	Continuum to death but not resulting in t	the underlying cause given in a at i.	1 Yes 2 ✔ No 3 Prot	
				topsy findings available ompletion of cause of
25. Was case referred to medical		26.Place of Death (Check only	one)	
examiner?	Hospital: 1 Inpatient 2 ✓ ER/Outpat	ient 3 DOA Other Nursing H	ome 5 Residence 6 Other	:
27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28a. Date of Injury (Month, Day, Year)	of Injury 28c. Injury at Work? 28c	d. Describe how injury occurred	
3 Suicide 6 Could no determin	ot be 28e. Place of Injury - At home, farm, s	street, factory, office building, etc. 28f	. Location (Street and Number or Ru or Town, State)	ral Route Number, City
	cian: To the best of my knowledge, death or er:On the basis of examination and/or invest and manner stated.			
29b. Signature and title of certifier	1	29c. License number	29d. Date signed (Moi	nth, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State Registra

30. Name and address of person who completed cause of heath (Item 23a

Assistant Medical Examiner

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

February 24, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Harvey David Levy 24, February 2009 8:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 10/19/1915 93 214-01-8045 1**1** M 2 □ F **Director** VA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Montgomery Bethesda 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8115 Split Oak Drive 20817 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 12 Yes 2 □ No. If Yes, Give 1943–1945 Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify: Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed - Owner Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nathan Levy Beatrice Cohn ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman S. Levy / Son 8115 Split Oak Drive, Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Removal from State Bayview Crematory 2/25/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heart **Physician** Congestive /Medical Due to (or as a consequence of): **Examiner** Ischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4M Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 ☐ Pending investigation 2 🗌 No

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, within 24 hours a To the Funeral I

Maryland 21215-0036

Baltimore,

2 Accident 6 ☐ Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

D0064871

29b. Signature and title of certifier Faz 29c. License number 29d. Date signed (Month, Day, Year) 2/24/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fazli 1801 R. Jefferson Rockville, mo 20852 31. Date filed (Month Day Year)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

oseph Lovell		1- For State	Certificate		u Mental Hygle		200	9 0616
Physic Medical Exam		1. Decedent's Name (First, Middle,Last) Joseph Lovett				Reg. No. te of Death onth Day bruary 24, 20	Year	3. Time of Death 1330 hrs
vieuicai Exaii	miei	4a. Facility Name (if not institution, give street and number		4b. City, Town, or			009 . County of Death	
		2923 Hamilton Avenue 2nd Floor		Baltimore	· .	-		
Funera Directo		055-44-5010 1X _{M 2} F	ge (In yrs. last birthday) 56	If Under 1 Year Months Days	r If Under 24Hrs. 8, E s Hours Min. 12	Pate of Birth (MM/ 2/20/195	2 Foreig	hplace (State or n NY untry)
w any		Usual Residence of Decedent 10a. State 10b. County MD	10c. City, Town or Loc	ation	Baltimore			10d. Inside City Limits
daryland 28a-f show 1 at once.	Director	10e. Street and Number		10f. Zip Code		10g. Citi:	zen of What Cour	1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	I Dire	2923 Hamilton Avenue		2121			USA	
death wi	Funera	11. Marital Status 1 X Never Married 2 Married Armed Forces' 3 Widowed 4 Divorced (15 Yes 2 17 Yes 2 1	? If		panic Origin? (Specify , Mexican, Puerto Rican specify:	, etc.)	White, etc.	can Indian, Black,
5 72 hours in "naturi	eted t		during		ion (Give kind of work di . DO NOT use retired)	one. 16b. h	Kind of Business/I	ndustry
5-0036 led within ? Hygiene. other than	Completed	0	none		y handicapp		none	·=·
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	17. Father's Name (First, Middle, Last) Joseph Russel Lovett			18.Mother's Name (First Anna Mari		,	
MD 21 ad 2 should lith and Me m 27 is man	은	19a. Informant's Name/Relationship (Type, Print) Joseph Scanlon / Nephew	19b. Maili 30 I	ing Address (Stree Matthews	t and Number or Rural F Lane, Topsh	Route Number, Ci	ity or Town, State 04086	, Zip Code)
Fe, s I ar f Hea Fite er tr		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from St 4 Donation 5 Other Specify:		osition (Name of cer other place) rematory	Date 2/27/2		Location - City or anover,	
Baltimo permit Page Department o Important:		21. Signature of Funeral Service Licensee Dorota		Maryland	of Facility cremation 413, Baltin	Service	S 21 203	
Physician /Medica		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.						Approximate Interval Between Onset and
xamine		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Due to (or as a cons	Cardiovascular Di equence of):	isease				Death
	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons	equence of):					
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60, ate be en	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome the second seco	me of pregnancy			236	d. Date of delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/I	23b. Was decedent pregnant in the past 12 months?	2 F	Fetal death 3 Other (Specify)	Ectopic pregnancy	_=	,	Day Year
P.O. B es that the di gned by the	/ Phy		h but not resulting in the	e underlying cause g	jiven in Part I.	23e. Did tobacco	use contribute to	the cause of death?
S, P.O. puires that the signed by the detached		Chronic alcohol use				1 Yes 2		ably 4 🗸 Unknown
Division of Vital Records, rate after the law require stander death. a Director: After this certificate has been side in by the fineral director, page 2 should be led in by the fineral director, page 2 should be						24a. Was an autopsy performed? ✓ Yes 2 N	prior to death?	topsy findings available ompletion of cause of
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital:			of Death (Check only or Other			
of Viting Physical After this	1 -1	1 V Yes 2 No Inpatie 27. Manner of Death 28a. Date of Inju (Month, Day,)	ent 2 ER/Outpatie			ne 5 Reside Describe how inju	nce 6 Other	: Scene
ion of tending Ph death. tor: After t	ation	1 Natural 5 Pending 2 Accident Investigation	'ear)	1 1	res 2 No			
Division pital or At ours after deral Direct filled in by	Certification:	3 Suicide 6 Could not be determined (Specify)	njury - At home, farm, str	reet, factory, office b		ocation (Street a	nd Number or Ru	ral Route Number, City
Division To the Hospital or Attention within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examon and manner stated.						
	Me	29b. Signature and title of certifier		29c. Licenso			Date signed (Mor	
\cap		30. Name and address of person who completed cause of c	jeath (Item 23a)	0.0.1	VI.L.		ruary 25, 200	
4		Donna M. Vincenti, MD Assistant Medic	cal Examiner 11	11 Penn Street,	Baltimore, MD 21	201		
S Regis			ir's Signature	del.				

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Corv **Physician** 18 200 UNNIA /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death County of Death Examiner BURNIE HEN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In yrs. last birthday, Security Number **Funeral** Months 1 ☐ M 2 🔀 F Days Hours 360-34-5222 Nov 30, 1942 66 Iowa Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene important: if Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examination in the mutilised at once. 1 ☐ Yes 2√☐ No Director Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 104 4th Avenue SW 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. unk 11. Marital Status 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) sales distribution 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Catherine Elizabeth Saunders Bert Emland Johnson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 4th Avenue SW Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Ronald Licensee S. Wender, D 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shot k, or heart failure. List only one cause on each-line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain **Physician** /Medical Due to (or as a consequence of) Examiner (N Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (of as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 🖼 No Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 □Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Dr Glen Burnie

Amend #5 per FH g888 2/27/09 TT
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Kobert Myers 3:30 P M 00 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7165 OHIO AVE Itanover Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Numper 59 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Year) 07/31/1933 Maryland Months Days Hours 1 № M 2 🗆 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No MD Anne Arundel Hanover 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21076 7165 Ohio Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐Yes 2 No Specify. 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelyn Dorothy Krout John Veron Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $7165\ Ohio\ Ave.$, Hanover, MD 2107619a. Informant's Name/Relationship (Type. Print) Bruce Michael Myers/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Cremation Services 02/27/2009 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation services 21. Signature of Funeral Service Licensee 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Car 010 ulmonas 6 minutes disease or condition resulting in death) Due to (or as a consequence of): Cight year Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 No hronic DUSTRUCTIVE 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ∐ Yes 2 🕱 No

Physician /Medical Examiner

> and burial-tran

attending physician for use as the burial

cate has been signed by the page 2 should be detached

certificate

funeral

completely filled in by the

e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica

within 2.

The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

Examine

Physician/Medical

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Certification: To

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Physician

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Director

Funeral

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item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r

permit. Pages 1 and 2 sr Department of Health and Important: If item 27 Is n any injury or other traun once.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 🗌 Homicide

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)

5 ☐ Pending investigation

6 ☐ Could not be

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of c

D3765

200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Penderbrooke Drive Crownsville Serlemitsos John MD 2. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

			For State Registrar		State	of Marylar	nd / Dep <i>Ce</i>	artment <i>rtificate</i>	of He	ealth an <i>eath</i>	id Ment	al Hyg	giene , Rea. No. 4	2009	9 06167
	Physici		1. Decedent's Nam Ruth Arlin		e, Last)						2. D	ate of Dea	ıth	23, Year	3. Time of Death
- Co	/Medio		4a. Facility Name	If not institution	n, give street and no e ph ide d	umber) LCal C	enter	4b. City, T	Town, or L	ocation of D	eath OWSOI	3	4c. C	ounty of Dea	th Altimore
	Funeral Director		5. Social Security 1 216–32–376	7	6. Sex 1 □ M 2 X F	7. Age (In yrs. 74	last birthday, Yrs.	If Under 1 Months	1 Year Days	Hours I	Hrs. 8. D Viin. Jai	ate of Birth fonth, Day 1. 15,	1935	Co	thplace (State or Foreign ountry) Land
	pur w		Usual Residence of 10a. State	f Decedent 10b. County	_	10c. Ci	ity, Town or Lo	ocation							10d. Inside City Limits
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	the N	rect	10e. Street and Nu				00 11111	10f. Zip (Code				10g. Cítize	en of What Co	ountry?
	3a or	io	1705 Saman	tha Driv	Э			2105	50			U	nited	States	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modest Evan, for a last be neithed at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Marital 3 □ Widowed		ried Armed F	2 XX No ive	l.S. 13.	Was Decede If Yes, speci 1 □Yes 2	ify Cuban,	panic Origin , Mexican, P Specify:	? (Specify Yuerto Rican	es or No- , etc.)		. Race - Ame Black, Whit pecify: Whi	e, etc.
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and 2	d be filed v ental Hygie ked other i ic event, the	To Be Co	17. Father's Name Edward San	(First, Middle,	<u> </u>					18. Mother's			Maiden Si	urname)	
, Maryland	and 2 shoul salth and M n 27 is mar er traumat	μ.	19a. Informant's N Mr. Charle		hip (Type. Print) 5 (Husband)			ing Address (Town, State, 21050	Zip Code)
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Balt	permit. Depart Import any inj		21. Signature of F	uneral Service	Licensee		E 3	2. Name and Vans Fur Newpoint	Address Peral Driv	of Facility & Crema e, Fore	ation S est Hil	ervice l, Mar	s - Bo yland	el Air 21050	
			23a. Part 1. Enter shock, or he	the disease, or art failure. List	complications that only one cause on	caused the dea each line.	th. Do not en	iter the mode	of dying,	, such as ca	rdiac or res	oiratory ar	rest,		Approximate Interval Between
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The same	/Medical		resulting in death)		Due to	(or as a consec		2000 per 1, 1 per		print,					
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Vital	sician: The certificate rector, pag	Be C	25. Was case refe	rred to medica					- :	26. Place of			1		
of V	Physici r this cer ral direc			2000		Inpatient 2] ER/Outpatie			4 LI Nursi	ng Home	5 ☐ Resid	lence 6	□Other (Spe	ecify)
פת	ding P. h. After t funera	on:	27. Manner of Dea	5 Pendir	ig i i	e of Injury nth, Day, Year)	28b. Time of Injury		Bc. Injury a Work?			escribe h	ow injury	occurred	
Sio	Attending or death. ector: After by the fune	icati	2 ☐ Accident 3 ☐ Suicide	investi 6 ☐ Could	not be	a of Injury At h	lama farm et	M		es 2 □ No		anation (C	Na d d	At	Lunda Niverbay
Division	or Attendated after death	Certification: To	4 ☐ Homicide	determ	inod 28e, Plac	e of Injury - At h ding, etc. <i>(Sp</i> ec	ify)	reet, tactory,	опісе		281. L	cation (S	n, State)	Number or H	lural Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only one)		ng Physician: To the Examiner: On the and ma										
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	/		30. Name and add	ress of person	who completed cau	ise of death (Ite	m 23a) (Type	, Print)							
	e		ABDALI			M.D. 7	601 0	SLER	DRI	VE TO	JWSON	, ME	RYLE	AND 2	1204
	Sta Registi		31. Date filed (Ma		000	Registrar's Sign	ture ba	Kel							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** February Year Paul Wilson Moore Sr. 25,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Square 16. Sex Himore tranklin If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number (In yrs. last birthday) . Age Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F 235 14 9441 89 Director West Virginia Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits s 23a or 28a-f show 1 ☐ Yes 2 X No Directo Maryland Baltimore Essex the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2252 Monocacy Rd. 21221 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Modical Example once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 1 No Specify: Completed by WW II Specify: White 3₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ship Fitter Ship Building 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elzie Moore Mary Ellen Haught 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Miller (Daughter) 2252 Monocacy Rd. Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 3/2/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. Signature of Funeral Service Licensee 1407 Old Eastern Avenue Essex, Maryland 21221 23a.f /t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 21 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): pital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the furneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c, if ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 □Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2. No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral DI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

the Batimore MD2122

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

Fohn

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8.50 PM McNeill Cecil Scott 10 bruar 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Year) Months Days Hours 1 X M 2 □ F 79 220-24-1878 Director 06 30 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐XYes 2 ☐ No MD NA Baltimore 10f Zip Code 10e. Street and Number 10g. Citizen of What Country? 6 301 McMechen street 21217 U.S.A. items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 72 hours after 1 Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes X☐ No Specify Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry
Baltimore City 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than 12th grade College (1-4or 5+) **4yrs** Educator Public Schools Health and Mental Hygivem 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) pe Jerry Mc Neill Evertean Scott ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lolita McNeill-Daughter 1120 Cherryhill Road, Baltimore, Md 21225 permit. Pages 1 and Department of Health Important: If item 27 any injury or other to 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition M☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) Garrison Forest Vét 3/5/09 Owings Mills, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licenses Mompour Ave, Baltimaore, 4300 Wabash 21215 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. the 9 Unknown us been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy certificate 1 □Yes 2 No 2 □No 1 ☐ Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1∐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To funeral 27. Manner of Leath Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Attending 5 Pending investigation Natural within 24 hours after uses...

To the Funeral Director: After the funeral on the funeral or the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) lospital or At I hours after o 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - Sta	Registrar			Certificate of Death				Reg. No. 2009 06170		
Physician Lar	Physician /Medical 1. Decedent's Name (First, Middle, Last) Larry Stewar				Myles		2. Date of E Month O 2	Death Day	2009	3. Time of Death 7:25a. M
Examiner 4a. Faci	As Facility bloom of the standard transfer of the standard of			4b. City, Town, or Location of Death Baltimore			eath		County of Death	
Funeral Director 5. Social Security Number 6. Sex 7. Age (In yrs. let 180 M 2□ F 58					last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) Yrs. 03 01 50 MD				**	
0	te 10b. County		10c. City, T	own or Lo	cation				11	0d. Inside City Limits
Maryl Inda	D NA				more					1 Ses 2 No
or 28a-1s Or 28a-1s Or 28a-1s	eet and Number			<u> </u>	10f. Zip Code			10g. Citi	zen of What Coun	trv?
144] F 44]	4 Groveland	d Ave 2nd	floo	r	2	1215			U.S.A.	
D36 Instantion items after all, or items after all, or items after all, or items after all all all all all all all all all al	al Status Never Married 2□ Married Nidowed 4□ X Divorced	12. Was Decedent E Armed Forces? 1 ☑Yes 2 ☐ N If Yes, Give Year or Dates:		"	Vas Decedent of Hi fYes, specify Cuba □Yes 2 ☑ No	spanic Origin? n, Mexican, Pu <i>Sp</i> ec <i>ify:</i>	(Specify Yes or Nerto Rican, etc.)	10-	14. Race - Americ Black, White, e	
5-0 72 hc 72 hc dical	15. Decedent's I (Specify only highest g	Education rade completed)	1	6a. Decec	lent's Usual Occupa	ation Juring most of v	vorkino	16b. Kir	nd of Business/Inc	lustry
21215-0 ed within 72 hot ygiene er than "nature t, the Medical E t. The Medical E	ntary/Secondary (0-12)	College (1-4or 5-	+)	life. L	ne Tech)	3		Vorison	
12t Page 17. Fath	h grade er's Name (First, Middle, Las	2yrs		PIIO	nie rech		lame (First, Middi		Verizon	
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Maryla Maryla 12 should the and Maryla Maryla Maryla Maryla Maryla 13 and 14 and 15 an	ormant's Name/Relationship	(Type. Print)	1	19b. Mailin	g Address (Street a					Code)
	Myles-Daug	ghter			Walshi					21214
8 6 = 0	thod of Disposition Burial 2 X Cremation 3 l	☐ Removal from State	20b. Place ceme	e of Dispos etery, crem	sition (Name of natory or other place	e)	Date	20c. Lo	cation - City or To	wn, State
ti Page timen rtant;	Donation 5 ☐ Other (Spec	ify)	Metr		ematory	_	2/25/09	Ва	ltimore	, Md
Baltimo permit. Page Department of Important: If Important: Imp	ature of Funeral Service Lice	ensee) Ke	ke	Ma	Name and Addres rch F/H 00 Waba	West	. Balt	imor	e. Md	21215
23a. Pa	t1. Enter the lisease, or conce, or heart wilure. List only	mplications that cause y one cause on each line	t death. E	Do not ente	er the mode of dying	g, such as card	iac or respiratory	arrest,		Approximate Interval Between
Physician Immedi	ate Cause (Final or condition				colon cano					Onset and Death
/Medical resulting Examiner	j in death)	Due to (or as a								
Soguen	ially list conditions, ading to immediate	b Due to (or as a	CONSEGUEN	ce of):						
	Disease or injury	200 10 (0) 20 0	Consequen	00 01).					10	
certificate be executed ding physician and see as the burial-transit series with the second see as the burial-transit series with the second s	ated events in death) Last	c Due to (or as a	consequence	ce of):						
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X 6876 certificate be ding physici se as the bu ///////////////////////////////////	J.F.									
he death the death the death the death the death the death the atterment the death the	s decedent pregnant ne past 12 months?]Yes 2 □ No]Unknown	23c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal de	ath 3 🗀	Ectopic pregnancy Other (specify)			2	3d. Date of delive Month	ry Day Year
by Physical Branch Bart II. O	ther significant conditions	contributing to death bu	t not resulting	g in the un	derlying cause give	n in Part I.	23e. Did	tobacco us	se contribute to the	e cause of death?
vital Mecords, sician: The law requires to certificate has been signe rector, page 2 should be rector, page 2 should be get of the completed by get of the complete of the com	Hypertension						_ 1 🗆	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown		
al Hecorc The law requi cate has been s page 2 should Completed	Hepat		24a. Was an autopsy autopsy prior to comple			sy findings available				
The page	Seizu	re disorder					perf	ormed?	death?	
25. Was exam	case referred to medical	[Haraward					eath (Check only			
Physical direction of the second of the seco	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Hospital: 1 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Hospital: 1 Nursing Home 5 Residence 6 Hospital: 1 Nursing Home 5 Nursing Home									
VIVISION (1974) tal or Attending F tal or Attending F as affect death. The property of the funder	Natural 5 ☐ Pending Accident investigatio	28a. Date of Injury (Month, Day)	Year)	b. Time of Injury	28c. Injury Work? M 1 🗆 Y	at ? es 2 □ No	28d. Describe	how injury	occurred	
DIVISION I or Attending after death. Director: After din by the fune ertification	Suicide 6 ☐ Could not I	28e. Place of Injur	ry - At home,	farm, stre		63 2 110	28f. Location	(Street and	Number or Rural	Route Number.
Set in lead in	Homicide determined	building, etc.	. (Specity)				City or To	wn, State)		
29a. Certifier (Check only one) 29a. Details of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a sequence of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a sequence of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a sequence of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a sequence of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a sequence of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a sequence of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a sequence of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a sequence of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a sequence of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a sequence of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a sequence of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as a sequence of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of examination and/or investigation, in my o								ated. the cause(s)		
Sapr Sign	nature and title of certifier	201			29c. License	number		29d. Date signed (Month, Day, Year)		
	Jun to	all MD			D51788 (MD) 2-23-2009				2009	
30. Nam	and address of person who	A 13								
	Tim	Polk, MD	620	Bor	iton St.	Bel A	ir MD ?	41017		

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year MYRER ATHERINE 22 3.04 PM - FB 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BURHIE BAYTIMORE WASHING TON FLEN HOTP If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F Months Director 85 577-26-4227 April 10,1923 Washington, DC Usual Residence of Decedent 10a State 10b. Counfy 10c. City. Town or Location 10d. Inside City Limits show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experiment the notified at 1 X Yes 2 No Director Maryland Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 1212 Odenton Road, Apt 313 21113 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: þ 3 X Widowed 4 ☐ Divorced Specify: White Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h ပ Walter Julian Cooksey Mary Agnes Higdon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra Cecelia M. Lowman/daughter 1167 Carrs Wharf Road Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 2/25/2009 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 21. Sign to e of Funeral Service Lio M00957 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician ISCHEMIC BOWEL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) g physician and The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical as attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a 9 Unknown 9 Unknown Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>چ</u> 1 Yes 2 No 3 Probably 4 Onknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2.00No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of pertifier. 29c. License number 29d. Date signed (Month. Day. Year) 2005919 F-26 2009

DHMH 17 Rev 1/2001

10

State Registrar 31. Date filed (Month, Day, Year)

BALTIMORE WASHINGTON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BONNUE

32. Registrar's Signature

			1 _ State	tate of Marylar							
			Registrar 1. Decedent's Name (First, Middle, Last)			rtificate of Death			Reg. No. 2009 30 5 72		
	Physici					Month			Day Ye	7:00 a M	
	/Medio Examin		Bernard Elmer 4a. Facility Name (If not institution, give street and number)			Mory Februa 4b. City, Town, or Location of Death			ry 23, 200 4c. County of I		
-	LXaiiiii		1103 Muller Rd			Westmin			Carro.	11	
	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. 2□ F 81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr. Hours Min		th 9. 1 ^{1y,} 1 ^y 927 Ma	Birthplace (State or Foreign	
	0		Usual Residence of Decedent	1 40 80						Land to the on the be	
	arylar shov	ō	Maryland Carroll		ty, Town or Lo stminst					10d. Inside City Limits 1 ☐ Yes 2 No	
	the M 28a-1	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?	
	3a or		1103 Muller Rd.			21157			USA		
	ems (Funeral		Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent of f Yes, specify Cub	Hispanic Origin? (oan, Mexican, Pue	Specify Yes or Norto Rican, etc.)	- 14. Race	American Indian, Vhite, etc.	
36	be flied within 72 hours after death with the Maryland Hydjene. d other than "natural", or items 23a or 28a-f show event, I'm Medical Evanders.	by Fu	1 ☐ Never Married 2 ☐ Married ☐ 3 ☐ Widowed 4 ☐ Divorced	1 K∆Yes 2 ⊡ No lfYes, Give WW] YearorDates: WW]	II I	No 2 No	Specify:		Specify:		
Maryland 21215-0036	2 hour atural	ted t	15. Decedent's Educati	on	16a, Deced	dent's Usual Occu	pation		16b. Kind of Busin	ess/Industry	
215	thin 7%	Completed	(Specify only highest grade co	mpleted) College (1-4or 5+)			during most of wo	orking	U-1don		
7	ed wil lygien ner th	Con	12		lron	Worker	40 14 44 - 45 14	- (Fine A Addul	Welder		
and	ibe fil	Be (17. Father's Name (First, Middle, Last) Bernard J.		Mory		Goldie		Maiden Surname) Heiste	rman	
7	2 should be fi and Mental H is marked ot aumatic ever	일	19a. Informant's Name/Relationship (Type.	Print)		ng Address (Stree			er, City or Town, Sta		
ž	1 and 2: Health a tem 27 is		Jack Mory (Son)		1103	Muller	Rd., Wes	tminster	, MD 2115	7	
ore	es 1 a of He of Hem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	20b. F	Place of Disponentery, cren	sition (Name of natory or other pla	ice)	Date	20c. Location - City	y or Town, State	
	Pages tment of l tant: If Its jury or o		4 □ Donation 5 □ Other (Specify)	ntombment Lo						, Maryland	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Because it important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Madical Examinations as Larrathled at once.		21. Signature of Funeral Service Licensee						k Funeral ore, MD 2	The second secon	
			23a. Part . Enter the disease, or complicat	ons that caused the deat						Approximate	
	hysician		shock, or heart failure. List only one of immediate Cause (Final	ause on each line.		WFARC	92	, ,		Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	Due to (or as a conseq	11/11/11	IVTINU	10.0			HVU/C	
	Examiner	L	Sequentially list conditions, b.								
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89 ×	ding ph e as th	Med	IF FEMALE:								
Вох	eath certific attending p for use as	Physician/Me	in the past 12 months?	If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a	al death 3	Ectopic pregnan Other (specify)	су		23d. Date o Month	f delivery Day Year	
0	the di by the ached	hysi	1 □Yes 2 □No 9 □ Unknown	9 Unknown							
o. O.	I he law requires that the death cerminate has been signed by the attending I bage 2 should be detached for use as	by Pl	Part II. Other significant conditions contrib	uting to death but not res	ulting in the ur	nderlying cause gi	ven in Part I.	23e. Did to		te to the cause of death?	
ord	w require s been si should b	ted						1 🗆 \	res 2 10 No 3	Probably 4 Unknown	
Vital Records,	e law has b je 2 st	Completed						24a. Was autop	an 24b. Wer osy prio rmed? dea	e autopsy findings available r to completion of cause of	
la l	ysician: The is certificate hidirector, page		25 Man anno referred to medical				00 Flore / D	1 □ Yes	2 1 1	Yes 2 □ No	
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י סל	arng Phy h. After thii funeral c	n: T	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		ıry at		now injury occurred	<i>Эреспу)</i>	
Sior .	feath. for: Af the fur	catic	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1	Yes 2 No				
Division of	after d Direct Jin by	Certification: To	4 Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, stre fy)	eet, factory, office		28f. Location (8 City or Tox	Street and Number o vn, State)	or Rural Route Number,	
	o the hospital or Attending Physician: within 24 hours after death. To the Tuneral Director: After this certifica completely filled in by the funeral director.	Medical Ce	29a. Certifier (Check only one) 29a. Certifier 29a. Certifier (Check only one) 29a. Certifier 29a. Certifi								
	Io the Hos within 24 hd To the Fun completely	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date signed (A	fonth, Day, Year)	
	250		> Telisma.	ns		722	220		Februar.	24.2009	
	9+1		30. Name and address of person who comp	,	n 23a) (Type, I		1	,	February > 21.	24/	
	\		Ellis Mez, IND 31. Date filed (Month, Day, Year)	1645 LI	berry	Kd	Eldersi	bury, M.	p 21.	187	
	Sta Registr		FED 2 7 2000	ever S.	park			,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 С. MALCOLM MORRIS FEBRUARY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner CLINTON PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 X M 2 □ F 90 JAN. 24, MD Director 578-12-1012 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f show Examinar is ust be notified at 1 NYes 2 □ No Director WALDORF MD CHARLES 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2004 AMBER LEAF PL #T-6 20602 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. 3 MWidowed 4 Divorced BLACK er than "natur. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, The Monee. FORKLIFT OPERATOR 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) AMBER LEAF PL #T-6 WALDORF, MD REGINA B. PEGRAM / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN MEMORIAL CEM. 02-26-2009 SUITLAND, MD 21. Sign the of Funeral Source Lices ee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 SUITLAND ROAD SUITLAND, MD GRAY DONALD R. 23a. Part 1 Enter the disease, of shock, or heart failure. Lis Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or y one cause on each line. Immediate Cause (Final disease or condition resulting in death) NEUMONIA Physician /Medical Due to (or as a consequence of) Examiner NEMIR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 ☐No ed by the detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OPROLIFICATIVE DISORDER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 ☐Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Mapner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation death. I Director: A d in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as seeds.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Ou. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) カナー UPPERMARLBORD MD OSIA, 31. Date filed (Month, Day, Year) FEB 2 7 2009 State Registrar

			For State Registrar	State of Mary		artment of I		ind Ment	tal Hygiene	2000	06174
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		2413 Long Ridge Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)				Reiste:				ltimo	
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	he Ma 28a-f	Director	New York Otsego 10e. Street and Number	R	ichfiel	d Sprine	gs		10g Citi	zen of What C	
	Mith With I		466 McRorie Road			13439					oundy:
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21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or items 23a or 28a-f show event, the Modical Evertiner must be notified at	ģ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □Yes ¾□No If Yes, Give Year or Dates:		If Yes, specify Cub 1 □Yes 2 X No		, Puerto Rican	n, etc.)	Black, White	
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ary	v) = 40 3	F	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mail	ng Address (Street				r Town, State,	Zip Code) 13439
Σ	nd 2 alth a 27 is		Henry Mlodynia		466M	cRorie_F	Road.I	Richf	ield Sp	rings.	New York
altimore,	of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	amoust from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Lo	cation - Čity or	Town, State
Ë	nit. Pages artment of ortant: If it Injury or o		4 □ Donation 5 □ Other (Specify)	inoval from State	Springfi				19	w Yorl	
Ball	permit. Page Department of Important: If any Injury or once.	j.	21. Signature of Fyneral Service License	ullo-	Cemete 6	Name and Address	ess of Facility	Marz Road.	ullo Fu Baltimo	neral re,Mai	Chapel, P. A
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the cause on each line.	e death. Do not er	ter the mode of dyl	ng, such as c	cardiac or resp	piratory arrest,		Approximate Interval Between Onset and Death
N.	Physician		Immediate Cause (Final disease or condition resulting in death)	- PA	noru	tic Ca	mce	1- M	etastat	0	motes
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	To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by t	Medical C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of r er: On the basis of ex and manner stated	camination and/or i	nvestigation, in my	opinion, deat	th occurred at	the time, date and	l place, and du	e to the cause(s)
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			30. Name and address of person who cor	npleted cause of deat	h (Item 23a) (Type	Print)	. 0	0	les no	15	
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ANL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Rosa Selma Nicoli February 19, 2009 9:27 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 121 Chevy Chase Street Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) February 13, 1924 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min Pennsylvania 578-26-6559 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinas must be notified at Maryland Montgomery Gaithersburg Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 121 Chevy Chase Street United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify Specify: ≥ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Fischbach Katherine Unknown ဥ 19a. Informant's Name/Relationship (Type. Print)
Sandra M. Praske/ Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418 Tschiffley Square Road, Gaithersburg, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 24, 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland Gate of Heaven Cemetery: 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Rockville, 21. Signature of Funeral Service Licenses M01544 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 lnc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 18 Months Immediate Cause (Final **Physician** Ureteral Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) law requires that the death certificate be executed and burial-tra resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the attending p nse IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ sign be 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed Physician: The certificate 1 ☐ Yes 2 ☐ No 1∐Yes 2⊠No After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1∐ Yes 2∭XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director;

completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D54378 February 20, 2009 100 30. Name and address of person who complete cause of death (Item 231) 11-7., Print) 2730 University Boulevard, #400, Wheaton, Maryland 20902 Cheryl Aylesworth, M.D. 31. Date filed (Month, Day, Year) Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 25, 2009 February 4:20 а.м 01ey Elizabeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Gaithersburg Shady Grove Adventist Hospital 8. Date of Birth (Month, Day,) OCL 21, 9. Birthplace (State or Foreign Country) Kentucky 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. . Year 915 Min. Hours Months Days 1 □ M 2 € F 285-22-0875 93 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 □ No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20877 415 Russell Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Management Analyst U.S. Air Force 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Susan Goodlett Vernon Mayes 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) $7812\,$ Horseshoe Lane Potomac, MD $20854\,$ 19a. Informant's Name/Relationship (Type. Print) Susan S. Mitchell (Trustee)

Physician /Medical

If Item 2

permit. Pages Department of Important: If It any Injury or c

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran burial-

attending physician for use as the burial Physician/Medical the signed by t þ Completed page 2 s has certificate director, Be this After this death.

ဥ 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Examiner IF FEMALE: 9 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide

29a. Certifier

(Check only

1 - For State Registrar

10a State

Director

Funeral

Q Q

Completed

Be

Physician

/Medical

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedlent Eventual or notified at

Pages 1 and 2 should be filled within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or iten

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

death with the Maryland

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underhind Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5 Pending

investigation

6 Could not be determined

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

M00982

Duenmours

Due to (or as a consequence of)

Due to (or as a consequence of):

Due to (or as a consequence of):

3 Ectopic pregnancy 5 Other (specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Feboog7,

933 Gist Ave. Silver Spring, MD 20910

22. Name and Address of Facility Rapp Funeral & Cremation Service

23e. Did tobacco use contribute to the cause of death?

23d. Date of delivery

Day

Year

Month

20c. Location - City or Town, State

Beltsville, MD.

Approximate Interval Between Onset and Death

75

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29b. Signature and title of contifier 30. Name, and address of person who completed cause of death (Item 23a)

Hospital:

28a. Date of Injury (Month, Day, Year)

and manner stated.

D.20198

29d. Date signed (Month, Day, Year)

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ell Ave. Gaithersbur MO 2. Registrar's Signature

hin 24 hours after death the Funeral Director

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Medical

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 12:54 A M OQUINN 00 ern 2 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltmore altimor 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days 1 M 2 7 F 82 228-46-2567 VA Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ns 23a or 28a-f show 1 Yes 2 No Director BALTIMORE N/A MD10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21205 USA 5034 E. EAGER ST Funeral of Health and Mental Hygiene.
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ir other traumatic event, the Medical Evantine The 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2X No Specify þ 3 ☑ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) APARTMENT COMPLEX JANITOR 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JESS LESTER MAE LEE ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALTIMORE, MD 21206 5411 OMAHA AVE EDDIE O'QUINN-SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 2/26/09 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Funeral Service Licenses 6415 BELAIR RD BATLIMORE, MD 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine enmana physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) signed by the a 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 X Yes 2 🗌 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐Yes 2 No 1 ☐Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 X Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu

28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Raven Blod,

State Registrar

Medical

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 2009 **Physician** 4:45 P M **OBERMAN** ROSE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE MILFORD MANOR NURSING HOME BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Hours Days 1 □ M 2 🗶 F 'nD 06/07/1925 83 219-18-7670 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 X Yes 2 □ No Director N/A BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6937 BLANCHE ROAD USA 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2X No WHITE Specify: Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ADELMAN** NORMA HARTMAN ABRAHAM ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6937 BLANCHE ROAD, BALTIMORE, MD 21215 CHARLES OBERMAN / HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 02/26/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens SOL LEVINSON & BROS., INC. REISTERSTOWN ROAD - PIKESVILLE, MD 21208 8900 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Coltante 2 2

Division of Vital Records, P.O. Box 68760,

Hospital Ar Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran certificate has been signed by the rector, page 2 should be detached After this certific funeral director, I within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Myclical Evanting must be notified at

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once.

Physician

/Medical

Examiner

2 should be filed within 72 hours after death with in and Mental Hygiene.

is marked other than "natural", or items 23a or items.

Baltimore, Maryland 21215-0036

Part II. Other significant conditions of		1 Yes 2 No 3 Probably 4 Unknown					
	multe,		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No			
25. Was case referred to medical		26. Place of Dea	ath (Check only one)				
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing H	lome 5 ☐ Residence 6 ☐	Other (Specify)			
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could net be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	ysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investig and manner stated.						
29b. Signature and title of certifier		29c. License number	29d. Date s	igned (Month, Day, Year)			
1	Mil	D27569	21	123/09			
30. Name and a best of person with	admpleted cause of death, (Item 23a) (Type, Print)	(838 €	Neeve To	e Rd Zwe			

State Registrar

31. Date filed (Month



DHMH 17 Rev 1/2001

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24,2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 25, 2009 12:43 P^M /Medical MARYDELLA PIERNE FEBRUARY 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 235 Hunters Run Terrace Be1 Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 M 2 N Yrs. **Director** 1922 Maryland 217-12-9320 86 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28e-f ahow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 📆 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 235 Hunters Run Terrace 21015 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: þ 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Beatrice Eversole Deise Ernest (nmn) Funk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 Is any injury or other tra <u>othce.</u> Robert A. Pierne / Son P.O. Box 1011, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ♥ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, Maryland Moreland Memorial Park 2-27-09 21. Signalure An Funeyal Se Nice Licensee 22, Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear railure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOTIA **Physician** /Medical Due to (or as a consequence of): **Examiner** cestive en Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitel or Attending Physician: The law requires that the death certificate be exequisd burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. physician Physiclan/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?, 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 -NO nerel Director: After this certification of the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier D55306 nD

State Registrar 9106 Philadelphia Rd Sute 200 Bottimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year). ...

FFR 2 7 2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #30 per DVR 9888 2/2//09 TT State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death /onth 800 PM 2009 FEB. 23, PIPER MICHAEL JOSEPH 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE 7405 ST. PATRICIA COURT DUNDALK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months Days JUNE 10, MD. 1946 62 215-44-1395 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No BALTIMORE DUNDALK MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 UNITED STATES 7405 ST. PATRICIA COURT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 💹 No WHITE Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) VETERANS JOB SERVICE REP. V.A. 10TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LAUREL HELEN FOREMAN RAYMOND J. PIPER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7405 ST. PATRICIA COURT, DUNDALK, MARYLAND 21222 CHRISTINE BELTON/DAUGHTER Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State GLEN BURNIE, MARYLAND ATLANTIC CREMATORY 3/2/2009 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature Fune | Service Licens 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 n 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1) iseas terrosc disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 □ Yes 2 No 2 No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) xaminer? Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

Examiner that the death certificate be executed attending physician and for use as the burial-tran Ö ٣. Division of Vital Records, cate has been signipage 2 should be or Attending Physician: this funeral After t

Physician

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

2

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

wher than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evanther must be notified at

is marked other

Pages 1 and 2 ment of Health a

permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.

Physician

/Medical

Examine Physician/Medical þ Completed Be Certification: To

27. Manner of Death

Natural 2 Accident To the Hospitar - within 24 hours after death.

To the Funeral Director: After a state of the funeral price of the 3 ☐ Suicide 4 Homicide Medical 29a, Certifier (Check only one)

State Registrar 29b. Signature and title of certifier

5 Pending

investigation

6 ☐ Could not be determined

and manner stated.

29c. License number

28c. Injury at Work?

1 ☐Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip Militello, MD22 S. Greene St. Baltimore, MD 21201

31. Date filed (Month, Day, Year)

registrar's Signatur

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year <u>09</u>:10 ^{A™} Sonia de Pointis 21, 2009 February 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Unde Hours Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Year) Min Davs Months 1 □ M 2 🖾 F 82 577-92-0101 9, 1926 Brazil Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 1 ☐ Yes 2X No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 20854 11116 Lamplighter Lane **Brazil** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 X Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: White 3 Widowed 4 Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant Embassy of Brazil 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rene de Pointis Germaine Lumay 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Germaine P. Wells/ Niece 11116 Lamplighter Lane, Potomac, Maryland 20854 20b. Place of Disposition (Name of Care of Heaven 20c. Location - City or Town, State 20a. Method of Disposition Februar 27. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Cother (Specify) Entombment 2009 Silver Spring, Maryland Mausoleum 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 M01532 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septic Shock disease or condition resulting in death) Due to (or as a consequence of): Urinary tract infection Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) pneumonia Due to (or as a consequence of) pelvic/sacral Fracture If yes, outcome of pregnancy

1 Live birth 2 Fetal death IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day oecify) use given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

"natural", or items 23a or 28a-f show

the Medical

Director

Funeral

Completed by

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Maryland

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Ilth and Mental Hygiene. 27 is marked other than "r r traumatic event, Ithe

of Health

item 2

Department of Important: If it any injury or o

Maryland 21215-0036

Baltimore,

319091011616

burial-transit the attending pl for use as t the detached cate has been signed by page 2 should be detact certificate the funeral director, this 24 hours after death.

that the death certificate be executed

Box 68760,

P.0.

Records,

Vital

Division of

The

or Attending Physician:

Hospital

Physician/Medical Examiner ģ Completed Be Certification: To filled in by

1 ∐ Yes 2 L 2N o 9 ∐ Unknown	9 ☐ Unknown
rt II. Other significant condition	s contributing to death but not resulting in the underlying ca
chronic renal i	ailure

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 24 No

25. Was case referred to r				26.	Place of Dea	th (Check only one)		
examiner? 1 ∑XYes 2 ☐ No	Ho	ospital: 1 ☐ Inpatient 2 🛭	ER/Outpatient 3 □ [OOA Other: 4	☐ Nursing H	lome 5 Residence	6 ☐ Other (Specify)	
2 ✓ Accident	Pending investigation	28a. Date of Injury (Month, Day, Year) Jan. 23, 2009	28b. Time of Injury 15:00 PM	28c. Injury at Work? 1 □ Yes	2⊠No	28d. Describe how inj Tripped wa		hallway
	Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	y)	ory, office		28f. Location (Street a City or Town, Sta	te)	
		Home				11116 Lamplia	ghter Lane, Po	tomac, Maryland
29a Certifier 1DXC	ertifying Physi	ician. To the hest of my kno	wledge death occurre	ed at the time d	ate and place	and due to the cause	(e) and manner as sta	ted

29b. Signature a

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print) 30. Name 4

and manner stated.

Joseph Rothstein, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814 Robert 31. Date filed (Month, Day, Year) 2. Registrar's Sig

State Registrar

completely

within 2 the

Medical

one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5,19b per fh g889 3-11-09 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Reg. No. 2009 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 9:45PM **Physician** EBRUARY 22, 2009 Mary Louise Petti /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Futurecare Chesapeake Arnold Anne Arundle If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 213-09-5491 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Yrs. Maryland Director 92 07/18/1916 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Stevensville Directo Maryland Queen Anne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 111 Sillen Plantation Road USA 21666 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2 No 50 Baltimore, Maryland 21215-0036 Specify Specify: White Completed by 3 Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Heelth and Mental Hygien Important: if Item 27 Ie marked other than any Injury or other treumatic evant, Item 2008. Sales Clerk Department Store 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Iampieri Maria Sfrattoni Plantation Rd.

111 Sillen Perkey, Stevensville, Maryland 21666

Date 20c. Location - City or Town, State 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bernadette Hoofnagle- Daughter 20b. Place of Disposition (Name of comptery, crematory or other place)
Garrison, Forest 20a. Method of Disposition

1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cemetery 03/03/2009 OwingsMills, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 Pad I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA Pnysician END STAGE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, page 2 should be 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes or Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification; To After the 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural Injury To the Hoepital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier FEBRUARY 23, 2009 noncen D575 31 , ms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nigo millersville Veteransliwy 8601 July 204 31. Date filed (Month, Day, Year) 32. Registrar's Siggature State FEB 27 2009 back Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 20 2009 Month **Physician** 0418 AM. tebruary Ina Louise Rock /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hagerstown Washington Washington County Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 12, 9. Birthplace (State or Foreign Country) WEst Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 74 1935 Director 227-52-1976 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2√∑ No Funeral Director Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21742 333 Mill Street USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕅 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. white Be Completed by Specify: 3 Widowed 4 Divorced of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, In Midical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) healthcare nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William McKinley Crowder Helen Sue Williams ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois O'Hara/friend 19108 Olde Waterford Road Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition to = 6 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department If Important: If any Injury or 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Fineral Service Licensee RONAID S Wade, Div Baltimore, MD 21201 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, Inter the disease or complications that caused the death. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner acomi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of) P.O. Box 68760. ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the updarlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. a www U 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 12 No 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier anlicken St 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Her 812010091 DR SHALFAB 2 31. Date filed (Month, Day, Year) Registrar's Signatur State Registrar

09-01138 Ch

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of I	Death	Reg. No. 2009 061	00
Physicia		egistrar 1. Decedent's Name (First, Middle,Last)		Date of Death John Day Year 2107 hrs	
edical Exami	_	Charles Roberts		Month Day Year 2107 hrs ebruary 7, 2009	71 (
		4a. Facility Name (if not institution, give street and number) 4b Good Samaritan Hospital	. City, Town, or Location of Death Baltimore	- Godiny of Beauti	
Funeral	- ;	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Feb. 18. 1957 New York	in
Director		218-70-6958 1XM 2F 51 Yrs.	Nontrio Bayo Trodio time	Feb 18, 1957 New York	
<u>*</u>	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n	10d. Inside City Limits	
ow any		MD Baltimore		1 X Yes 2 No	
Maryland r 28a-f sh ied at one	Director	10e. Street and Number 6307 Everall Avenue	10f. Zip Code 21206	10g. Citizen of What Country? USA	
D 21215-0036 should be filed with the Maryland should be filed within 72 hours after death with the Maryland and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f she is marked other than "natural", or items 23a or 28a-f she natified at once went, the Medical Examiner must be notified at once	_ L	11. Marital Status 1 XNever Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	Decedent of Hispanic Origin? (Specific Specify Cuban, Mexican, Puerto Rice Yes 2 X No specify:	fy Yes or No- an, etc.) 14. Race - American Indian, Black, White, etc. White Specify: 1-1-a-ck	
rs after	à.	or Dates:	s Usual Occupation (Give kind of work	done un 1/16b. Kind of Business/Industry unk	
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5-0036 Ited within 72 Hygiene. I other than	шb	9 0	Long House (C)	rst, Middle, Maiden Surname)	
5-0 Tiled w Hygic d othe	- 1	17. Father's Name (First, Middle, Last)	Alice J		
2121 ould be fi Mental marked	o Be	William Lee Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rura	al Route Number, City or Town, State, Zip Code)	
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ore, MD 21215-003 s. 1 and 2 should be filed within 55 Health and Mental Hygiener. If litem 27 is marked other the traumatic event, the Med her traumatic event, the Med		20a. Method of Disposition 20b. Place of Disposition		Date 20c. Location - City or Town, State	
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Baltimore, permit. Pages 1 am Department of Heal Important: If iten injury or other tra		21. Signature of Funeral Sevice Licensee Start Dangston Sta	ame and Address of Facility Arde Lte Anatomy Board	nt Cremation Svcs. 7522 Xonnellyabrimmanovere MD	
Physician		23a. Part . Enter the disease, or complications that caused the death. Do not enter the			
" - /Medical	e V	failure. List only one cause on each line. Immediate cause (Final disease a. Complications of Chronic Alcohol U		Death .	
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	L	Sequentially list conditions, Due to (or as a consequence of):			_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:10 PM February 24 Margaret Coughlin Roberts 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Calvert 11750 Asbury Circle Suite 103 Solomons 8. Date of Birth (Month, Day, Yea 11/7/1909 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 12 F Vrs Massachusetts 99 030-36-3283 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Solomons Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20688 U.S.A. 11750 Asbury Circle Suite 103 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2K Married White 1 ∐Yes 2 🔀 No Specify. 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Medical Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Thibodeau Ambrose Connelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11750 Asbury Circle Suite 103, Solomons, MD 20688 Roberts/Husband Clyde Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 2/26/2009 Hanover, Maryland 4 Nonation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Heart Failure Due to valvular disfunction Songestive Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Regurgital Due to (or as a consequence of): Routic Stayosis Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year 5 ☐ Other (specify)

Physician /Medical Examiner

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After this (funeral din

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10a. State

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Funeral Director

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Certification: To

Medical

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Predical Examiner must be notified at

Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, Ita Magone.

Pages 1

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

Natural

2 Accident

3 Suicide

4 Homicide

29b. Signature and title of certifier

in the past 12 months? 1 ☐ Yes 2 ☑ No

9 I Inknown 9 Unknown

23e. Did tobacco use contribute to the cause of death?

Part !!. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of

2009

1 ☐ Yes 2. 21No

25

24a. Was an autopsy performed 1 ☐Yes 22 No 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 5 Pending investigation 1 ☐Yes 2 ☐No 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only and manner stated.

FET Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

110 Hospital Road #310 Prince Frederick, MD 20678 David Tardio MD 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

32 Registrar's Signature

2121 Baltimore, Maryland W

920

Box 68760,

The law requires that the death certificate be executed P.O. ospital or Attending Physician: hours after death.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Renda **Physician** 405ar10 February 2 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Itimove Izabeth a WYSING (enter If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**X** M 2 □ F 83 09/30/1925 New York 111-18-1249 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 1 ☐ Yes 2X No Catonsville Baltimore MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21228 912 Rolling Road, #205 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyres 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White If Yes, Give Year or Dates: WWII ģ 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Law Attorney 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Farah Giuliano Frank Renda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2117 Old Frederick Road, Catonsville, MD 21228 Thomas Renda, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Charles Cemetery 3/5/2009 Farmingdale, NY * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune I Service L 22. Name and Address of Facility Macken Mortuary T. Harman 52 Clinton Avenue, Rockville Centre, NY 11570 23a. Part1. Enter the dijeas shock, or heart failure. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nterval Between List only one cause on each line. Onset and Death Ischemic Immediate Cause (Final cardiomyorath Physician disease or condition resulting in death) /Medical Examiner OVOMAYV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse ju fice of): Examine 25 The law requires that the death certificate be executed me iabe attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ acciden 3 ☐ Probably 4 MUnknown vascular Cerebra 1 ☐ Yes 2 ☐ No certificate has been si irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an ronic 065 CTOUL 1 Yes 20 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 X Nursing Home examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) Director: After thi 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

Avenue

Baltimore,

30. Name and address of person who completed duce of death (Item 23a) (Type, Print)

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Registrar's Signatury

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31. Date filed (Morth, Day, Year)

Mina

Mn

	Division of Vital Records, P.O. Box 68760,
->	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

			For State Registrar	Pleas	e Type or Pr State of M	aryland / C	Эера	delible Inkartment of Elificate of L	lealth and l		_	ible.	ns I	Ω
	Physici /Medic		1. Decedent's Nam	eu	re street and number)			av ks 4b. City. Town, or		2. Date of De Month	Party Day	Year 2009 y of Death	3. Time of Dea	
T.	Examir Funeral Director	ier	The Johns 5. Social Security N 224-32-2 Usual Residence of	Hopkins Hollumber 6.128	lospital	01	Yrs.	Baltimore If Under 1 Year Months Days		. 8. Date of Bi	Th Th	9. Birthp Count Vir	ginia	
he Marylan	28a-f show otified at	Director	VA	10b. County King Ge	orge	10c. City, Town	n or Loc h1g1	ren					0d. Inside City Li 1 ☐ Yes 2X	
eath with t	ns 23a or must be no	Funeral Dir	10e. Street and Nur 15099 Da 11. Marital Status	nhlgren R	12. Was Decedent	Ever in U.S.	13. V	10f. Zip-Code 2248 Vas Decedent of H		pecify Yes or No	10g. Citizen of USA	ce - America		
.036 ours after d	al", or iten Examiner	þ		ied 2 XMarried 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	l If	Yes, specify Cuba ☐ Yes 2 1 No	n, Mexican, Puerto Specify:	o Rican, etc.)	Bla	ick, White, e	etc.	
d 21215-0036 filed within 72 hours after death with the Maryland	ne. Ihan "natur e Medical	Completed	(Spec	15. Decedent's E cify only highest gr ondary (0-12)			(Give I	lent's Usual Occup kind of work done o OO NOT use retired homemake	during most of wor)	rking	16b. Kind of E		dustry	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aft	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Co	17. Father's Name					Homemake	18. Mother's Nai Katy Rol		own h			
, Mary and 2 shou	aalth and M n 27 is mar er traumati		19a. Informant's Na Charle:	ame/Relationship s K. Spat				g Address (Street Box 1165				, State, Zip	Code)	
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Of VI Physicia	this cert	: To B	examiner? 1 Yes 2		Hospital: 1 Inpation		tpatient	3 DOA Other	4 - Nuising H		idence 6 Ot)	
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DHMH	Regist	_	FE	B 2 7 200	9 Berein	B. 4	bay	4	-					

09-01378 Robert Shifflett Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

tobert Shifflett	1- R:	State of Maryland / Department of Health and Mental H	ygiene _{Reç}	2009	06189
Physician Medical Examine	1	. Decedent's Name (First, Middle, Last)	Date of Death Month February 1		3 Time of Death 1740 hrs
Medical Examine		Robert Shifflett Ia. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
		4040 Birch Drive Huntingtown		Montgomery	
Funeral	5	Social Security Number 1 Year If Under 24Hrs Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min		(MM/DD/YYYY) 9 Birt Foreig	n
Director		278-22-4626 1XM 2F 80 Yrs. World Bays Hours Will	Apr 18	, 1928 Co.	untry) Ohio
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*		MD Calvert Huntingtown			1 Yes 2 X No
the Maryland a or 28a-f show Hiffed at once.	3 1	Oe. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	itry?
th the Maryland 23a or 28a-f sho notified at once		4040 Birch Drive 20639		USA	
or death with or items 23	1	 Marital Status Was Decedent Ever in U.S. Never Married Married Married Forces? Married Forces? 		14. Race - Americ White, etc.	can Indian, Black,
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6 72 hc an "n: cal Ex		Elementary/Secondary (0-12) College (1-4 or 5+)	wed) dillo		
5-0036 led within 72 hour Hygiene. other than "matu	<u> </u>	12 0 17. Father's Name (First, Middle, Last) 18 Mother's Name	e (First Middle M	recycling	unk
215- be filed ntal Hy rked of		Robert Lewis Shifflett	, , , , , , , , , , , , , , , , , , ,	,	unk
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e, ME 1 and 2 sl Health ar item 27	Ļ	Mary Woodward/niece 7905 Audebon Avenue A	Alexandr	ia, VA 223	
Baltimore, MD Z permit. Pages 1 and 2 shou Department of Health and N Important: If item 27 is njury or other traumatie		1 Burial 2 Cremation 3 Removal from State crematory or other place)		<u></u>	
Baltimo permit. Page Department of Important: injury or oth		4 Donation 5 X Other Specify: in state 21 Signature of Funeral Sugar Licensee 22 Name and Address of Facility			
Depart Impo		21 Signature of Euneral Sprus Licensee Rouse S. Wade Director State Anatomy Bo			e Street
Physician	1	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure-List only one cause on each line	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease			Death
		or condition resulting in death) Due to (or as a consequence of):			
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
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the des	≥L	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did to	bacco use contribute to	the cause of death?
P.C.			1 Yes	2 No 3 Prot	pably 4 Unknown
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Reco The law cate has	<u>ق</u> ا		perfor	med? death? 2 ✓ No 1 Ye	es 2 No
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Division Hospital or Attent 34 hours after death Funeral Director: tely filled in by the	Certification:	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc.		Street and Number or Ru	iral Route Number, City
Divis ospital or A hours after uneral Dire	إق	Suicide 6 Could not be determined (Specify)	or Town, St	tate)	
		29a Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	d due to the cause	e(s) and manner as stat	ed. ie cause(s)
To the within 2 To the complete	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated 29b. Signature and title of certifier 29c. License number	at the time, date	29d Date signed (Mo	
		O.C.M.E.		February 17, 200	
	-	30. Name and address of person who completed cause of death (Item 23a)		L	
		Jack Titus MD. / Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 2	1201		
Sta Registr		31. Date fifed (A. Arthritis, Day, Year) 82. Registrar's Signature Service Ser			

DHMH 17 Rev 1/2001 OCME 2006

State of Manyland / Department of Health and Mental Hygiene

		1	For State	tate of Maryland	-	tificate of L			i. No.	
Ç.			Registrar Decedent's Name (First, Middle, Last)					Date of Death Month	2009 Day Vear	3) into on Death
*	Physicia	_	Mary Jane Su	tton				Feb.	27 2009	5:00 a ^M
No.	/Medic Examin		a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, or	Location of Death		4c. County of Death	
			Carroll Hospice			Westmi	nster If Under 24 Hrs.	9 Date of Birth	Carroll	place (State or Foreign
	Funeral Director	2	13-30-1486	2½ F 7. Age (In yrs. In	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,) Jan • 5	rear) Cou	ryland
	and t	- H	Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Lo	cation				10d. Inside City Limits
	Maryl f sho	Į.	Maryland Carrol	l Ma	nches	ter				1 □ Yes 2 □XNo
	a or 28a st be notif	Funeral Director	10e. Street and Number 3717 Water Tank	Rd. P.O. B	ox 57	10f. Zip Code 0 211	02	10	g. Citizen of What Cou	untry?
36	be filed within 72 hours after death with the Maryland ntal Hyglene. ed other than "natural", or Items 23a or 28a-f show ed other than "natural", or Items 23a on 28a-f show event, the Medical Examiner must be notified at	by Funera	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I □ Yes 2☑ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
Maryland 21215-0036	in 72 hou n "natura ledicai E	Completed	15. Decedent's Educat (Specify only highest grade of	ompleted)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of work		6b. Kind of Business/I	ndustry
212	d within giene. er than " the Mee	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	Flee	t Super			Black &	Decker
nd	e filed al Hygi I other event, t	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M Blevin		
yla	should be ind Mental marked o umatic eve	ဥ	John Wesley Sutt		101 11-75	- Add (Chana)			City or Town, State, Z	(in Cade)
Var	an an		19a. Informant's Name/Relationship (Type Charles Sutton -							# 2110 Manchester
	1 an Heat em 2 ther		20a. Method of Disposition	20b. P	I	sition (Name of matory or other place			0c. Location - City or	
m of	9 = 5		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)					March	2,2009 M	onkton, MD
Baltimore,	permit. Pag Department Important: I any Injury c		21. Signature of Funeral Service Licensee	Ø	2:	2. Name and Address	ss of Facility Ec.	khardt	Funeral (Chapel P.A.
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death	. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	multiple	2 5	oclero	212			Onset and Death
1	/Medical Examiner		recoming in dealing	Due to (or as a consequ	ience of):	m on At	1~			
		Jer	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ience ut):	to boar	13			
	cuted nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
68760,	ificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a consequ	lefice of).					
387	ficate physi s the b	edical	d.							
Box .	eath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ØNo 9 □ Unknown	c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3	⊒Ectopic pregnancy □ Other (specify) _	,		23d. Date of del Month	ivery Day Year
P.0	w requires that the dobeen signed by the should be detached		Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	ınderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	
rds	quires an sign	ed by						1 ☐ Ye	es 2⊠No 3□Pr	robably 4 Unknown
Division or Vital Records,	isician: The law re s certificate has bee lirector, page 2 sho	Completed						24a. Was ar autops perform	y prior to ned? death?	utopsy findings available completion of cause of
ita	ilan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?			12.		th (Check only on		
۲ \	hysic his ce	은	1 ☐ Yes 2 No		ER/Outpatie		4 🗆 Nursing ri		ence 6 Other (Spe	city) HOSPICE
on c	ing P	inoli:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wor	ryat rk? Yes 2∐No	280. Describe no	w injury occurred	
ivisio	or Attending frer death. Director: After in by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, s			28f. Location (St City or Town	reet and Number or R , State)	ural Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:	Medical Ce	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my kno er: On the basis of examina and manner stated.	owledge, dea ation and/or i	th occurred at the ti nvestigation, in my	me, date and place opinion, death occi	and due to the curred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	Fo the vithin 2 Fo the Fo the comple	Mec	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mont	th, Day, Year)
	F>F0		> Olymatc	am, a		DS	51705		01-27.	-2004
	3 1		30. Name and address of person who con	349 malc	mo	DR,	nestm	instoc	02-27. , MD 21	1157
	St Regis	ate	31. Date filed (Manth, Day, Year) FFR 2 7 2009	2. Registrar's Sign	ture for	ves .				

		1	For State Registrar	State of Marylan		rtment of H tificate of L			ene 201	09 06191
O:			Decedent's Name (First, Middle, Last)					2. Date of Death	Day Vo	3. Time of Death
	Physicia		John J. Sherry				•	Month February		11:02 A.M
	/Medic Examin	al -	4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, or	Location of Death		4c. County of E	Death
1	LAGIIIII		3801 Cantebury Road	Unit605		Baltin			_	N/A
8	Funeral	:	5. Social Security Number 6. Sex	7. Age (In yrs. 82		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9.	Birthplace (State or Foreign Country)
	Director		207-14-4807	1 2□F 82	Yrs.			Oct.UI,I	926 Pr	riladelphia,PA.
	pu ,	- F	Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	cation				10d. Inside City Limits
	aryla shov d at	_			altimor					1 ⊠Yes 2 □ No
	he M 28a-f otifie	Directo	Maryland N/A	Bo	TETHOL	10f. Zip Code		100	g. Citizen of Wha	at Country?
	with t	늅	3801 Cantebury Road	Unit605			1218		United	States
	eath	Funeral		. Was Decedent Ever in U.	S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-		American Indian,
_	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	ᇤ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 2 No	1	t Yes, specity Cuba 1 □ Yes 2ŽINo	n, mexican, Puerto Specify:	Hican, etc.)		White, etc.
9500-61212	urs a	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		ILITES ZEFINO	эреспу.		Specify:	White
2	72 ho natur lical	Completed	15. Decedent's Educa (Specify only highest grade)	tion completed)	16a. Dece	dent's Usual Occupa kind of work done o DO NOT use retired	ation Juring most of work		6b. Kind of Busin	
7	ithin ne.	현	Elementary/Secondary (0-12)	College (1-4or 5+)	1	er of Heal			Trea	ler of the asury of Maryland
	led w lygien her th		17. Father's Name (First, Middle, Last)		l'idiid 90	- O1 11CO.		e (First, Middle, M		rary rand
Maryland	be fi	Be	Thomas A. Sherry					Stenson		
ž	s 1 and 2 should F Health and Men Item 27 Is marke other traumatic	ို	19a, Informant's Name/Relationship (Type	Print)	19b. Mailir	ng Address (Street a				ate, Zip Code)
<u>8</u>	d 2 sho th and t7 Is ma traum		Ms. Renee Nacrelli	•	421 [Dumbarton	Road E	altimore	Marylar	nd 21212
ā,	s 1 and f Health item 27 other tr	Į įį.	20a. Method of Disposition			osition (Name of matory or other place		Date 2		ty or Town, State
ᅙ	000-	- 5	1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) ☐	moval from State			· rep.	28 , г	imonium.	Maryland
altimore,			21. Signature of Funeral Service Licensee		D2	2. Name and Addres	s of Facility	on Punor	al Croma	tion Ctr D A
ä	permit. Departr Imports any Inje	4 14	Mm- 4	guro, la	F	325 York	Road I	imonium,	Marylan	ation Ctr.,P.A.
	- X		23a. Parti. Enfer the disease, or complice shook, or heart fallule. List only one	ations that caused the deal	th. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arre	st,	Interval Between
	Physician		Immediate Cause (Final disease or condition	ACUTE	MY	OCARDÍA	IN	FARCTIC		Onset and Death
4	/Medical		resulting in death)	Due to (or as a consec		J4 (KD-1/1)				
В	Examiner		Sequentially list conditions b.							
	P #	ner	Sequentially list conditions, ff b. cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consec	quence of):					
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consec	ruonee ett:					
8760,	Attending Physician: The law requires that the death certificate be executed reath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit			Due to (or as a consec	querice oi).					
87	cate t	Completed by Physician/Medical	d.							
9 ×	leath certific attending p I for use as	/Me	IF FEMALE: 23	c. If yes, outcome pf pregn	ancy				23d. Date of	of delivery
8	atten for u	cian	in the past 12 months?	1 Live birth 2 ☐ Fet 4 Pregnant at time of	al death 3[□Ectopic pregnancy □ Other (specify) _	/		Month	
o.	the d	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown						
ص	w requires that the d been signed by the should be detached	y P	Part II. Other significant conditions conf	ributing to death but not res	sulting in the u	ınderlying cause giv	en in Part I.	23e. Did tob	acco use contribi	ute to the cause of death?
p	quires n sign	D D	CHRONIC VENOU	5 STASIS I	ULCES	S BOTH	LOWER	1 🗹 Ye	s 2□No 3	☐ Probably 4 ☐ Unknown
00	s bee	lete	CORD			EX	TREMIN.	E 24a. Was ar	24b. We	ere autopsy findings available or to completion of cause of
æ	The lav te has age 2 :	E			-			perform	ned? dea	ath? ☑Yes 2☑No
ital	ilcian: The certificate ector, pag	Be C	25. Was case referred to medical				26. Place of Dea	th (Check only one	9)	
>	Physical this ceral direc	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐] ER/Outpatie	nt 3□ DOA Oth	er: 4 □ Nursing H	ome 5 Reside	nce 6 □Other	(Specify)
0 U	ng Ph fter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe ho	w injury occurred	ı
<u>.</u>	endlr sath. or: Al	atic	2 ☐ Accident investigation				Yes 2 ☐ No			
Division or Vital Records, P.O. Box	or Att ter de irect n by 1	Certification:	3☐ Suicide 6☐ Could not be 4☐ Homicide determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, st <i>ify)</i>	reet, factory, office		City or Town	eet and Number , State)	or Rural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		200 Codifice 4 December 1	ician: To the best of my kn	owledge dog	th occurred at the ti	me date and place	and due to the co	ause(s) and man	ner as stated
	Hosp 24 hor Fune stely f	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	er: On the basis of examin and manner stated.	ation and/or i	nvestigation, in my	opinion, death occu	rred at the time, d	ate and place, an	d due to the cause(s)
	o the athin to the comple	Mec	29b. Signature and title of certifier			29c. Licens	e number	25	9d. Date signed ((Month, Day, Year)
	FSFS		· cuyansome	no		010	6619	7	EBRUAR	y 25, 2009
7	10		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type	, Print)				
	TO 1		30. Name and address of person who con C. VERGARA - SO. 31. Date filed (Month, Day, Year) FFR 2 7 200	ARES 994	O FRA	ANKLIN	SOWARE.	DR. NO	TTINGH	MM, MD. 21236
15	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature A	ale				
	Regist	rar	 	y come	14. 19					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** M 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner enue Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9 Birthplace (State or Foreign (Country) **Funeral** Year Hours Min 1□M 2以F March 20, Director North Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Madical Examiner is ust be notified at 1 X Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 222 once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. 2 3 Widowed 4 □ Divorced Slac Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Balto. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be lahmar ဂ 19a. Informant's Na e/Relationship (Type. Print) aughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow, tate, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) em 22. Name and Address of Facility 21. Signature of Funeral Service License 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner ANCRE Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) Yes 2/ No ed by the a 9 Unknown 9 Unknown sate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐Yes 2 ☐No 2 No within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/1Nc 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 → Natural 2 → Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2

State Registrar 30. Name and address of person who co

Year

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

22

oleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

17934

PAOL PL. BAYO NO 21207

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year STEED **Physician** GEORGE FEBRUARY 03 00AM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Director 218 28 3596 May 12,1931 Ohio Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Essex 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 704 Platinum Avenue 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1½ Yes 2 □ No IfYes, Give Year or Dates: Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 ☐No Specify: White þ 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Welder Bethlehelm Steel permit. Pages 1 and 2 should be filed v Department of Heath and Mental Hygic Important: If item 27 is marked other I any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Steed Collins Genevieve ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Steed-Zacot (daughter) 909 Oak Hollow Road Anna Texas 75409 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory Inc 2/26/2009 4 Donation 5 ☐ Other (Specify) Baltimore Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rone cause conclude ine. Approximate Interval Between Onset and Death art 1 Enter the disease, or cor hoc, or heart failure. List op Imme liate Cause (Final diseas or condition resulting in death) **Physician** Acute MYOCARDIAL INFARCTION HOUR /Medical Due to (or as a consequence of): Examiner 24 HOURS EPSIS Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine he attending physician and of for use as the burial-translaw requires that the death certificate be executed 2 WEEKS DIFFICILE INFECTION CLOSTRIDIUM Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f Ö 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown icate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1 **Y**es 2 No Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **☑** No 1☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P s after death. I Director; After t 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physiclen: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

State

Registrar

20 11

CHRISTINE

31. Date filed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

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RES-001

EASTERN AVENUE, BALTIMORE, MARYLAND

SMITH,

State Registrar 29b. Signature and title of certifier

SUBHADRA SHASHIDHARAN DEPT OF SURGERY 2. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

120208

29d. Date signed (Month, Day, Year)

02 22 2009

900 CATON AVENUE BACIMORE MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 3:15 P M 2009 25, James Howard Smith February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Mar. 12, 1 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days **Ж** М 2□ F 1925 Director Maryland 215-30-4978 Usual Residence of Decedent Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shor 1 Tyes 21 No Director Maryland Churchville Harford the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 3002 Rolling Green Drive 21028 USA Funeral death th and Mental Hygiene.
7 Is marked other than "natural", or items traumatic event, the Medical Examinating. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: \$ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Procurement Manager <u>Aeronautics</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi Margaret Elizabeth Treadwell William Ellsworth Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health C. Barbara Smith / Wife 3002 Rolling Green Drive, Churchville, MD 21028 other Department of Heal Important: If item 2 any Injury or other once. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Hillton Service Corp.: 3-3-09 Towson, Maryland McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Intracranial hemorrhage Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Autte Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: f yes, outcome of pregnancy I ☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy 1 ☐Yes 2 No : After this certification, I 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 DANO 1 hpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hor To the Fune completely fi (Check only one) and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

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James

ricgistiai

ORIGINAL

Zubair Kharal 500 upper Chesapeake Or. Bel Air, MD 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Vernor Dale Shaffer 4a. Fability Name (if frost institution, give street and number) 4b. Coly, Town, or Location of Death Shaffer 5b. Color Security Name of Shaffer Shaffe	2009 06196
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The state of the contribution of the contribut	n Surname)
Carol Shaffer Carol	City or Town, State, Zip Code)
Purpose of the purp	57673
Physician Marghan Naminer 23.3. **Art I. Elyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Like only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 25. **Condition resulting in death) 25. **Condition resulting in death) 26. **Condition resulting in death) 27. **Condition resulting in death) 28. **AMENDED 23a, 27, perME, 8890 4/6/09 TT 28. **Manual time of death of the preparant in the past 12 months? 28. **Manual time of death of the preparant at time of dea	c. Location - City or Town, State
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failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate or conditions or conditions, if any, leading to immediate or conditions or condition	Towson, MD, 21286 shock, or heart Approximate Interval
Immediate Cause (Final disease) or contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Extent Underlying Cause (events resulting in death) Last devents resulting in death devents resu	
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23c. If yes, Outcome of pregnant or the past 12 months? 1 Yes 2 No 9 Unknown 23c. Types, Outcome of pregnant or the past 12 months? 1 Yes 2 No 9 Unknown 23c. Types, Outcome of pregnant or the past 12 months? 1 Yes 2 No 9 Unknown 23c. Types, Outcome of pregnant or the past 12 months? 1 Yes 2 No 9 Unknown 23c. Types, Outcome of pregnant or the past 12 months? 1 Yes 2 No 3 Probable of prefnonce or pregnant or the underlying cause given in Part I. 23c. Types, Outcome of pregnant or the past 12 months? 1 Yes 2 No 3 Probable or prefnonce or pregnant or the underlying cause given in Part I. 23c. Types, Outcome or pregnant or the underlying cause given in Part I. 23c. Types, Outcome or pregnant or the past 12 months? 1 Yes 2 No 3 Probable or prefnonce or pregnant or the underlying cause given in Part I. 23c. Types, Outcome or pregnant or the past 12 months? 1 Yes 2 No 3 Probable or prefnonce or pregnant or the underlying cause given in Part I. 23c. Types, Outcome or pregnant or the past 12 months? 1 Yes 2 No 3 Probable or prefnonce or pregnant or the underlying cause given in Part I. 23c. Place of Death (Check only one) 23c. Place of Injury (Month, Day, Year) 23c. Place of Death (Check only one) 23c. Place of Death (Check only one) 23c. Place of Injury (Month, Day, Year) 23c. Place of Death (Check only one) 23c. Place of Injury (Month, Day, Year) 23c. Place of Injury (Month, Day, Year) 23c. Place of Injury (Month, Day, Year) 23c. Place of Death (Check only one) 23c. Place of Injury (Month, Day, Year) 23c. Place of Injury (Month, Day, Year) 23c. Place of Injury (Month, Day, Year) 23c. Place of Injury (Month, Day, Ye	23d. Date of delivery
The second of th	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probation 1 Yes 2 No 1 Yes	
The standard of the standard o	co use contribute to the cause of death?
24a. Was an autopsy performed? 1	Probably 4 ✓ Unknown
Performed? 1	24b. Were autopsy findings available prior to completion of cause of
25. Was case referred to medical examiner? 1	d? death?
examiner? 1	
27. Manner of Death 1	sidence 6 V Other: Scene
Natural 2 Accident 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 5 Pending Investigation 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rura or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 29a. Certifier (Cheek only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated and manner stated.	injury occurred
3 Suicide 6 Could not be determined (Specify) 3 Suicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, onice building, etc. (Specify) 3 Suicide 4 Homicide 29a. Certifier 1 Check only one) 29a. Certifier 1 Check only one) 29a. Certifier 1 Check only one) 29a. Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated and manner stated.	at and Number or Pural Pouts Number City
4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 5 Explain to the cause (s) and manner as stated (Check only one) 5 Explain to the cause (s) and manner as stated (Check only one) 6 Explain to the cause (s) and manner as stated (Check only one) 7 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated (Check only one) 8 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated (Check only one) 9 Explain to the cause (s) and manner as stated (Check only one)	
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the	and manner as stated.
	place, and due to the cause(s)
29b. Signature and title of certifier 29c. License furnise 29c. License 29c. Licen	d. Date signed (Month, Day, Year)
O.C.M.E. February 24, 2009	ebruary 24, 2009
30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Off D. State of Co. and Sec. 1	
State 31. Date filed (Month; Day, Year) Registrar FER 2. 7 2009 Live S. Agares Registrar	

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Hospital or Attending Physician: within 24 hours after death To the Funeral Director: completely To the

State Registrar

RESIDENT SHIVAKUMAR NARAYANAN.

29c. License number

29d. Date signed (Month, Day, Year)

RES-000.

24 09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

5601 LOCH RAVEN BLVD, BALTIMOIZE.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

32. Registrar's Signature

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Pation-t known 45: Edward Smith, Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4a. Facility Name (If not institution, give	e street and number)		4D. OII	y, rown, o	Location	Dealli		40. Count	y or Dealir	
Sinai Hospital .	f Baltimor	٠.			Limore			N/	A	
5. Social Security Number 213–32–1685 6. S	ex 7. Ag	e (In yrs. last birthe 74 Yr	Month		If Under Hours	Min	8. Date of Birth (Month, Day, AUG. 31	Year)	9. Birthp Coun	lace (State or Fore stry) MD
Usual Residence of Decedent 10a. State 10b. County		10c. City. Town of	or Location						1	0d. Inside City Limi
	GEORGES	LAUI							,	1 □ Yes 2 X 1
10e. Street and Number			10f. 2	Zip Code			1	0g. Citizen of	What Coun	ntry?
1016 TENTH ST				2070	7			USA		
11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Dec	edent of H	ispanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		ce - Americ	
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛂 Divorced	1 Yes 2 If Yes, Give Year or Dates:	No		2 X No				Speci		
15. Decedent's Ec (Specify only highest gra	lucation de completed)	16a. D	Decedent's Us Give kind of t life. DO NOT	sual Occup	ation during mos	t of worki	ng	16b. Kind of E	Business/Ind	dustry
Elementary/Secondary (0-12)	College (1-4or s	5±1	ARPENT		<i>''</i>			COMME	ERCIAL	1
17. Father's Name (First, Middle, Last)							(First, Middle, I	Maiden Surna	me)	
JOHN SMITH		140.	4 22 4 4 1	(0)			WAGNER	O': T	0:: 7:	
19a. Informant's Name/Relationship (JEAN KIEFNER-SIS			.016 T				al Route Number UREL, MI			Code)
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	ID am avel from State	20b. Place of D	Disposition (A crematory o	lame of r other plac	ce)		Date	20c. Location	- City or To	wn, State
4 □ Donation 5 □ Other (Specif		GARDEN			1		7/09	BALTIM	ORE,	MD
21. Signature of Funeral Service Licer	1300									HOME, INC
MATCI	PAR		6415	BELA	IR RD	В	ALTIMORE	E, MD 2	1206	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of		.γ Δ:	SLASE					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 ☐ Ectopic 5 ☐ Other						ate of delive	ery Day Year
Part II. Other significant conditions of	ontributing to death b	out not resulting in t	the underlying	g cause giv	en in Part I		23e. Did tol	pacco use cor	ntribute to th	ne cause of death?
Cof	D.						1 🗆 Y	es 2□No	3 ☐ Prob	ably 4 🖟 nkno
							24a. Was a autops	n 24b	. Were auto prior to cor death?	psy findings availal mpletion of cause o
							1□ Yes	2 🗷 No	1 ☐ Yes	2□ No
25. Was case referred to medical examiner?	Hospital:			DOA Oth	or:		(Check only on			
1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpation			DOA	4 🗆 140		me 5 Reside			y)
1 Natural 5 Pending 2 Accident investigation	(Month, Da	ny Year) Inj	ury M		k? Yes 2		zou. Describe no	ow injury occu	irreu	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of in building, e	jury - At home, farn tc. <i>(Specify)</i>	n, street, fact	ory, office			28f. Location (Si City or Town	treet and Num n, State)	nber or Rura	I Route Number,
	nysician: To the best miner: On the basis of and manner st	of examination and								
29b. Signature and title of certifier			1	29c. Licens	e number		2	9d. Date sign	ed (Month,	Day, Year)
		M, D.		Δ5	9062			Februar	y 24	2009
30. Name and address of person who								,		
Chad J. Hansen	MA 2	2401 W	Belved	cre	B-	1time	re Mo	2/2/5		
31. Date filed (Month, Day, Year) FER 2 7 2009	Severe 32. Hegisti	rar's Signature	12							

3. Time of Death

6:42 AM

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Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year ВW Richard Smith Snader 20 /Medical 7:00 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Lutheran Health Care Westminster Md Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1**X** M 2□ F Months Days 67 Director 213-44-6284 Sept.4, 1941 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. Medical Expuring must be notified at once. Director 1 ☐ Yes 2 🛣 No MD Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1301 New Windsor Road 21776 Funeral USA 12. Was Decedent Ever in U.S.

Armed Forces?

1 XYes 2 □ No
If Yes, Give
Year or Dates: Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 4 Farmer Dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Philip B. Snader Elizabeth Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trudy Jo Snader/wife 1301 New Windsor Rd. New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Pipe Creek Cem. 2/26/09 Linwood, MD 21. Signature of Funeral Service Livensee. 22. Name and Address of Facility Hartzler Funeral Home P.A. 0 St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** neumana ween /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or carrying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) P.0. been signed by the a should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? of Vital Records, ğ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEVIN 31. Date filed (Month, Day, Year) Registrar FER 2 7 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Frances Estella Smith 200 9 12:45 P February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Potomac Potomac Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) Months Days Hours Min 1 □ M 2 🖾 F 89 212-12-2191 Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits 1⊠Yes 2 No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 611 West Montgomery Avenue 20850 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21X No Specify: White Specify 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Welsh Pearl Gettings 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Lee Smith/ Son 1613 River Ridge, Williamsburg, Virginia 23185 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklaph Memorial March 2 2009 4 Donation 5 Dother (Specify) Rockville, Maryland 21. Signature of Funeral Service Lig 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/R88kVille; Maryland 26850 Montgomery Avenue M01498 104 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multi Organ Failure Months Due to (or as a consequence of) Arrythmia Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Sepsis Days Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Vascular Ulcer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Arthritis 1 🗆 Yes 2 🔼 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

certificate be executed

The law requires that

Hospital or Attending Physician:

Box 68760,

P.0.

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

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Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Interportant: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Mydical Evaminar must be notified at once.

Baltimore, Maryland 21215-0036

death with the Maryland

and burial-trar attending physician the as use P the detached been signed by should be detach has been page 2 s certificate

this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of

Exami Physician/Medical þ Completed Be P Certification:

25. Was case referred to medical examiner? 1 ☐ Yes 2 🔼 No 27. Manner of Death

1 XNatural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide

4 Homicide 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year).

28a. Date of Injury (Month, Day, Year) 28b. Time of

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number City or Town, State)

28d. Describe how injury occurred

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and addre s of person who completed cause of death (Item 23a) (Type, Print)

10810 Darnestown Road #202, Gaithersburg, Maryland 20878 Raman R. Tuli, M.D.

State Registrar

Medical



DHMH 17 Rev 1/2001

Registrar

Physician	ì
/Medica	ĺ
Examine	ľ

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	1 - State Registrar					rtificate of	Dealli		Reg. No.	2009	
)	Decedent's Name (Fig. 1)			wann-Jo	ones,	M.D.		2. Date of De Month	eath Day eb 24,	2009 Year	3. Time of Deat 12:15 P
r	4a. Facility Name (If no		e street and nur			4b. City, Town, o	Location of De Columbi		4c.	County of Death	ward
	5. Social Security Numb 579-48-553	4 1	ex □ M 2.24 F	7. Age (In yrs. In 75	as <i>t birthday,</i> Yrs.	Months Days	If Under 24 F Hours M	in. (Month, D	rth ay, Year) 3, 193 3	Cou	place (State or For intry)
_		b. County		10c. City	, Town or Lo	ocation	Columb	io.			10d. Inside City Lin
Director	MD 10e. Street and Number		ward			10f. Zip Code	Columb	ia	10g. Citiz	zen of What Cou	
	4905 Ten Mill	s Rd.					21044	1/0		U.S.	
ed by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐	Divorced	Armed Fo 1 Tyes If Yes, Giv Year or Da	2 No ve		Was Decedent of HIYes, specify Cuba 1 □Yes 2 ☑ No	Specify:	r (Specify fes of No lerto Rican, etc.)		14. Race - Ameri Black, White, Specify: Bla- nd of Business/Ir	etc. Ck
Completed	(Specify of Elementary/Seconda	. Decedent's Ed only highest gra try (0-12)	ode completed) College (1	-4or 5+)	(Give	e kind of work done DO NOT use retire	during most of i	working		Health	·
Be	17. Father's Name (First	st, Middle, Last))				18. Mother's I	Name (First, Middle		_	
ို	19a. Informant's Name	/Relationship (Frank S	Swann	19b. Mail	ing Address (Street	and Number or			Carter Town, State, Zi	p Code)
	Judith I. Ove	rby Daug	hter		J	5 Ten Mills R	d. Columb				
	20a. Method of Disposi 1 Burial 2 □ C 4 □ Donation 5 [remation 3		State Co	emetery, cře	osition (Name of ematory or other place of a Memorial Pa		Date ar 02, 2009		cation - City or T Clarksville	
	21. Signature of Funer		/	100535	_ 2	22. Name and Addre Slack Fu 3871 Old	neral Home	e, P.A. Pike Ellicott C	itv. MD	21043	
dical Examiner	sease or condition resulting in death) Sequentially list condition and the cause. Enter Underlyin Cause (Disease or injut that initiated events resulting in death) Last	ng ury	b. Cue to (or as a consequ	rence of):	NEY DIS					MONTHS
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ıysician/Med	IF FEMALE: 23b. Was decedent proin the past 12 mo 1 ☐ Yes 2 🔊 No	egnant nths?	1 ☐ Live I	tcome of pregna birth 2□ Fetal nant at time of d lown	death 3	☐ Ectopic pregnand	y		4	23d. Date of deli Month	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5,20b per fh, 23e per doc g888 2-27-09 vt State of Maryland Department of Health and Mental Hygiene State amend #5&20b Per FH G889 3/11/09 JH Registrar Amend Item#5perInf. C894,8/17/09, WS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Elizabeth A. Trotta 02 /Medical 4a. Facility Name (If not institution, give street and number) Fown, or Location of Death 4c. County of Death Examiner Sayare sedale Date of Birth (Month, Day, Year)
Oct. 29,1939 9. Birthplace (State or Foreign Country) West Virginia Age (In yrs. last birthday, **Funeral** Min 1 □ M 2 🗙 F Months Davs Hours 69 Yrs. Director Oct. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified at Dundalk Maryland Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or important: If item 27 is marked other than "natural", or items 29a or any jury or other traumatic event, the Medical Examiner must be a one. 21222 405 Westfield Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify **≙** 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mariano Trotta Mildred Flloyd 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2820 Blue View St. Redding, CA Tina M. Trotta (Daughter) 96002 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition unk Date 20c. Location - City or Town, State Pages ' 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 03/05/2009 □Donation 5 □ Other (Specify) Towson, Maryland 21. Signa are of Funeral Service Licensee Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, MD 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatio /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dike to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical as attending properties of IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ **+**∀es 2 No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page 2 certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 28a. Date of Injury (Month, Day Year) P 1 🗌 Yes 2 ER/Outpatient 3□ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral dir 27. Manner of Death 1 X Natural 2 ☐ Accident 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ZI Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated, 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kes 00000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Gangala Baltimore Alay Sauare 31. Date filed (Month, Day, Year State Registrar

			1 - State of N	laryland / Dep Ce	ertificate of L		_	giene Reg. No2 () ()	9 06204
	Physic	on	1. Decedent's Name (First, Middle, Last)				2. Date of De		3. Time of Death
M	/Medi		Geraldine Wills				Febru	URY 15,20	09 2024 1
	Exami	ner	4a. Facility Name (If not institution, give street and number	" Ilon Lal	4b. City, Town, or	Location of D	eath	本c. County of □	eath
	Funeral		5. Social Security Number unk 6. Sex 7.	age (In yrs. last birthday	f Under 1 Year	If Under 24	Hrs. Date of Bir	th a	Birthplace (State or Foreign
	Director		1□M 2∏ F	87 Yrs.	Months Days		Hrs. Date of Bir (Month, Da Nov 5,	iy, Year) 1921	Country) unk
	put		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L					
	/arylan f show	5	MD NO. County		timore				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the Marragaria	Director	10e. Street and Number	Dai	10f. Zip Code			10g. Citizen of What	
1	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Madicel Examil wir mast be redified at	al D	1701 N. Eutaw Street #619		212	17		USA	ood.iii.y.i
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36	safte , or it	by Fu	1 Never Married 2 Married 1 ∏Yes 212	I No	1 ☐ Yes 2X No	Specify:	perto rticari, etc.)	Specify: 1	hite, etc.
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Maryland	2 should be filed with and Mental Hygiene is marked other tha aumatic event, Inc.	으	10- 10- 10- 10- 10- 10- 10- 10- 10- 10-						
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<u>)</u> ē,	is 1 and 2 of Health item 27	1	20a. Method of Disposition		osition (Name of matory or other place		Date	20c. Location - City	or Town, State
Baltimore,	Pages tment of tant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state		matory or other place	"			
alti	permit. Departr Importa any inju		21. Signature of Funeral Service Vicensee . 17		2. Name and Address State Anat	s of Facility	ard 655 W	Raltimo:	ro Stroot
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-/	/Medical Examiner		resulting in death) Due to (or a	s a consequence of):	, 0				
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	ate be executed physician and the burial-transit	Examiner	trial militated events	re De	enyev	ofu			
8760,	cate be execu physician and the burial-trar	E	resulting in death) Last Due to (or as	a consequence of):	2001	Pot	(100 TI	-	
687	physics the b	dical	d	nes p	reerry	4	Jose 11		
Box (To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	in the past 12 injuntis?	2 Fetal death 3	☐ Ectopic pregnancy			23d. Date of Month	delivery Day Year
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S, F	es tha igned be det		Part II. Other significant conditions contributing to death	out not resulting in the u	nderlying cause giver	n in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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a	n: Th ficate r, pag						perfor 1 □ Yes	med? death 2 ☐ No 1 ☐ Y	?
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Division of Vital	r Atterderie de lirecto	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of In building, e	jury - At home, farm, str ic. (Specify)	eet, factory, office		28f. Location (Si City or Town	treet and Number or	Rural Route Number,
Ω	pital o		29a. Certifier 1 Certifying Physician: To the hest					,	
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death, to the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis and manner s	of examination and/or in	h occurred at the time vestigation, in my opi	e, date and pla inion, death oc	ace, and due to the cocurred at the time, d	cause(s) and manner late and place, and d	as stated. ue to the cause(s)
	To T	Σ	29b. Signature and title of certifier		29c. License	number	_ 2	9d. Date signed (Mo	nth, Day, Year)
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			30. Name and address of person who completed cause of a HNU AA HCAAY. If 31. Date filed (Month, Day, Year).	n.D.40	Maryla	and a	Gioneral	2 HOSP	tol
	Sta Registra	•	FEB 2 7 2009	ar's Signature	are			,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month DILLIAM JILLIAM FEBRUARY 9:24 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MERCY MEDIGAL CENTER BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**∑** M 2□ F Days Year) 34 Yrs. Director 214-92-1567 7-26-1974 N.C. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must te nother at Director MD N/A Baltimore 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5203 Nuth Avenue 21206 Funeral USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No þ Specify 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important; If item 27 is marked other the any Injury or other traumatic event, I'm!, once. Construction Co. 12th grade Management N/A17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) James Cobb 2 Velma Ree Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Velma Ree Williams-Mother 5203 Nuth Avenue Balto, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenmount 4 ☐ Donation 5 ☐ Other (Specify) 2-28-2009 | Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATIO Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SARCOMA Sequentially list conditions, if any, Lading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner LOTOLUND DEFICIENCY SYNDROME the burial-trar Due to (or as a consequence of): Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 □Yes 2 No 2 □No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident (Month, Day, Year) 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide

The law requires that the death certificate be executed Box 68760, Ö نَ Records, Vital Hospital or Attending Physician: ₽ Division

has

certificate

this

72 hours after

Baltimore, Maryland 21215-0036

after death Director: within 24 hours a 0

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

MONIQUE JAMES, MEDICAL DOOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year Marion Whiting /Medical 23 2009 1:35p. 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Nursing Chapel Hill Home Randallstown
If Under 1 Year | If Under 24 Hrs. | Baltimore 8. Date of Birth (Month, Day, 09 27 Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Year) 1 □ M 💥 🗆 F Yrs. Director 086-07-0695 94 1914 VA Usual Residence of Decedent death with the Maryland 10a, State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Mudical Examiner must be rediffed at 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2015 Burnwood Road Funeral 21239 U.S.A. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo þ Specify: Black 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Cosmetologist <u>Beauty</u> Salon permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Beverly McCormick Minnie Fowlks ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2015 Burnwood Road, Baltimore, Md 212 ce of Disposition (Name of Date 20c. Location - City or Town, State Keith Brown-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 2/27/09 Baltimore, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West Nome 4300 Wabash Ave, Baltimore, Md Kumpaur 21215 23a. Part1 Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Dause (Final **Physician** disease or condition resulting in death) 78ar3 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a I be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been has 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 🔼 No 1 ☐ Yes 2 🗆 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No Certification: To this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a, Certifier (Check only the within To the 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) 25, 200 9

State Registrar

DEMINIST Rev 1/2001

FR 2 7 2009 Server S. April

25

32. Registrar's Signature

Maws

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tibell

31. Date filed (Month, Day, Year)

09-01615 Albert Warfield Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar	Certificate	of Death	Reg.	No. 200	9 0620	
Physician/ ledical Examine		Warfield		2. Date of Death Month D February 24		3. Time of Death 1815 hrs	
	4a. Facility Name (if not institution, give street 718 E. Fort Avenue	and number)	4b. City, Town, or Location of Baltimore		4c. County of Death		
Funeral Director	5. Social Security Number 213–26–9706 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 1 Year Yrs. Hours	8. Date of Birth(2/21/		place (State or htry) MD	
Aaryland 28a-f show any Lat once.	Usual Residence of Decedent 10a. State 10b. County MD N/A	10c. City, Town or L	Baltimore C	ity		0d. Inside City Limits 1XX Yes 2 No	
the Maryland 3a or 28a-f sh otified at once		t	10f. Zip Code 2123		10g. Citizen of What Country? UNited States		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygbird. Important: If item 77 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examber must be notified at once. To Re Completed by Funeral Director	3 Widowed 4 Divorced If Yes, or Date	rmed Forces? Army Yes 2 No Give Year Korea	Was Decedent of Hispanic Origin for Yes, specify Cuban, Mexican Yes 2 XX No specify: edent's Usual Occupation (Give	, Puerto Rican, etc.)	14. Race - America White, etc. Specify: 6b. Kind of Business/Ind	White	
0036 within 72 hour giène. her than "natt Medical Exa	Elementary/Secondary (0-12) Co	ollege (1-4 or 5+)	ng most of working life. DO NOT Mail Carrier	use retired)		al Service	
215-0036 be filed within 7 minal Hygiène. rked other than ent, the Medica	Tolon	Warfield	18.Mother	's Name (First, Middle, Ma Margaret	iden Surname) Briggerman		
MD 21 d 2 should 1 th and Mer n 27 is mar rumatic ev		Jr./Nephew 140		ourt, Severn	er, City or Town, State, 2 Maryland 2	Zip Code) 21144	
Baltimore, permit. Pages I and Department of Heal Important; If iten injury or other tra	20a. Method of Disposition 1 XX Burial 2 Cremation 3 Ret 4 Donation 5 Other Specify:	noval from State crematory Cedar H	sposition (Name of cemetery, or other place) Hill Cemetery	3/3/2009	20c. Location - City or To Baltimore	, MD	
Physician Physician	21. Signature of Funeral Service Licensee V	s that caused the death. Do not er	Name and Address of Facility harles L. Steven 501 East Fort her the mode of dying, such as c	ens FuneralHe Avenue, Balt ardiac or respiratory arrest	ome, Inc. imore Maryl	and 21230 Approximate Interval	
/Medical xaminer	The state of the s	osclerotic Cardiovascular (or as a consequence of):	Disease			Between Onset and Death	
iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause	(or as a consequence of):			-		
executed ian and ial - transit	a.	(or as a consequence of):					
'60, sate be execubly sician and be burial - tr	UNPENDED AME	NDED					
lox 687 eath certific attending provide as the	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnancy Live birth Pregnant at time of death Unknown	Fetal death 3 Ectopic Other (Specify)	c pregnancy	23d. Date of delivery Month Da	y Year	
ires that the de signed by the detached for the detached for the by the detached for the by by	Part II. Other significant conditions contril		the underlying cause given in Pa		acco use contribute to the		
duires t quires t en signi uld be d				1 Yes 24a. Was an	2 No 3 Proba	bly 4 V Unknown	
of Vital Records, by Physician: The law requirer ther this certificate has been signered director, page 2 should by			26.Place of Death	autopsy perform	prior to co ed? death?	mpletion of cause of	
/ital	examiner? Hospital	1 Inpatient 2 ER/Outpa	Other:		esidence 6 V Other:	Scene	
ion of Virtending Physicath ton: After this the funeral di		a. Date of Injury (Month, Day, Year)	e of Injury 28c. Injury at Work	,	w injury occurred		
Division opital or Attending ours after death reral Director: Aft filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide (3	Be. Place of Injury - At home, farm,	street, factory, office building, el	tc. 28f. Location (Stroor Town, State	eet and Number or Rura te)	al Route Number, City	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the		the best of my knowledge, death of basis of examination and/or investance stated.					
T % T %	29b. Signature and title of certifier	·	29c. License number		29d. Date signed (Mont	,	
	30. Name and address of person who comple	ted dause of death (Item 23a)	A O.C.M.E.	OCME	February 25, 2009	<u></u>	
P	Theodore M. King, Jr., MD.	ssistant Medical Examine	er 111 Penn Street, Ba	Itimore, MD 21201			
State Registra		32. egistrar's Signature	have				

			For State Registrar	State of Ma	ryland / Depa		lealth and N	Mental Hygi	•	06208
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Deborah L.	Web	b			2. Date of Death Month	Day Year	3. Time of Death 2:28 A M
	Examin Funeral Director		4a. Facility Name (If not institution, give s 2407 Tionesta Road 5. Social Security Number 214-62-7158	d, Apt. 2A	(In yrs. last birthday) 54 Yrs.	4b. City, Town, or Lansdo If Under 1 Year Months Days	Wne If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan 27		th imore thplace (State or Foreign puntry) laryland
	ryland ihow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	ith the Ma or 28a-f s	Directo	MD Baltimo		Δ	Lansdow 10f. Zip Code 2122		10	Og. Citizen of What Co	
(0	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Industrial if them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Inc. Medical Eventing must be notified at once.	Funeral Director	2407 Tionesta Roa 11. Marital Status 1 □ Never Married 2 M Married	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 ▼No	ver in U.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amo Black, Whit	erican Indian, e, etc.
9-003	2 hours a atural", o	ted by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		71	Specify:	. 1	Specify: 16b. Kind of Business	White /Industry
21215-0036	d within 7 giene. er than "n Inc Medi	Completed	(Specify only highest grade	College (1-4or 5+) (Give	dent's Usual Occup kind of work done o DO NOT use retired comemaker	during most of work	ang	Cv	vn Home
Maryland	uld be file Mental Hy Irked othe Itic event,	To Be (17. Father's Name (First, Middle, Last) Irvin Willaim En	os			18. Mother's Nam Mildred	e (First, Middle, M LEllen H	laiden Surname) lenley	
, Mary	ind 2 shoi alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Ty) Earl Webb - Husban	-					City or Town, State,	•
Baltimore,	Pages 1 anent of He		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 ponation 5 Pether (Specify)	emoval from State	20b. Place of Dispo cemetery, cren Atlantic	sition (Name of natory or other plac	e)	Date 2	Clen Burni	Town, State
Balti	permit. Departr Imports any Inju		21. Signature of Funeral Service License	TODE	000	. Name and Addre	ss of Facility Am		neral Home sdowne, MD	of Lansdowne
	Physician /Medical Examiner		23a Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line	he death. Do not ent	er the mode of dyir	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death MONTHS
H	earn certificate be executed attending physician and for use as the buriel-transit	Examiner								
6876	Tincate by ng physici as the bu	ledical	\							
O. Box	the death cery the attendir ched for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at 1 9 ☐ Unknown	23d. Date of de Month	23d. Date of delivery Month Day Year				
							acco use contribute to	o the cause of death?		
Vital Records,	ystcian: The law require is certificate has been si director, page 2 should t	Completed by	25. Was case referred to medical				OC Plans of Days		prior to death? No 1 □ Yes	utopsy findings available completion of cause of
of Vil	nysicia this cert al directo	To Be	examiner? 1 ☐ Yes 2 No		at 2 ER/Outpatier		er: 4 Nursing H		nce 6 Other (Spe	ecify)
Division	lo the hospital or Attending Fra within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification: To	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day, 28e. Place of Injur building, etc.	Year) Injury y - At home, farm, str	M 1 □	y at ⟨? Yes 2 □ No	28d. Describe hor 28f. Location (Str City or Town	reet and Number or R	ural Route Number,
<u> </u>	No the Hospital of within 24 hours all To the Funeral D completely filled it	Medical Ce			examination and/or in				ause(s) and manner a ate and place, and du	
,	vithin To the compl	Me	29b. Signature and title of certifier	maken .	mi)	29c. Licens	e number		od. Date signed (Mon	

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUL GORMCEY GOO (atom)

31. Date filed (Month, Day, Year)

FEB 2 7 2009

A Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Joseph Man Wong ľð, 20ď9 February 10:35 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Montgomery Hospice Casey House | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 4, 1945 5. Social Security Number 6. Sex 1 X M 2 ☐ F 9. Birthplace (State or Foreign Funeral Country) China 579-66-0155 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It w Medical Eva miret must be retified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring Director 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20906 12515 Littleton Street United States Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: Asian 1 ☐ Yes 2 X No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Produce Clerk Retail Grocerv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Beck Ng Yim Yip Wong ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) York Har Sue Wong/ Wife 12515 Littleton Street, Silver Spring, Maryland 20906 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parklawn Memorial Park 24, 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Rockville M01544 300 West Montgomery Avenue, Rockville, Maryland 20805-2805 Inc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic Lung Cancer /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any Luding to mind a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed physician ar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical ast IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? 1 Yes 2 No page his certificate h 2 No 1 □ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \bowtie$ Other (Specify) Hospice 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the t 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Koueltehou, mi) 20063748

State Registrar

31. Date filed (Month; Day, Year) EEG 2 7 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouatchou, M.D., 201 East University Parkway, Baltimore, Maryland 21218

February 19, 2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
amend 1 tem 26 per doc 9888 2-27-09 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** Month Year OSE WOLF 08:10 A M 0 2 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 220-09-4111 91 01/02/1918 Director MD Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at MD 1 XYes 2 No Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 6317 PARK HEIGHTS AVENUE, #214 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ural", or iten Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite ury or other traumatic event, the Medical Examine. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify: ρ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OFFICE MANAGER INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JULIUS LAZARUS ျှ BESSIE BLUMFNFFLD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHEILA CHARKATZ / DAUGHTER 7301 PARK HEIGHTS AVE., #407, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH EL MEMORIAL PARK 02/26/2009 4 □ Donation 5 □ Other (Specify) RANDALLSTOWN, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CORONARY Physician DISEASE ARTERY /Medical Due to (or as a consequence of): Examiner DISEASE (ADRIL STENOSIS VALVULAR if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ INSUFFICIENCY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed KECURRENT UNINARY INFECTION 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2: autopsy performed 2,**□** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 K ER/Outpatient 3 □ DOA Certification: To → Hersing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) nours after death.

neral Director: After the filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 5 ☐ Pending investigation Injury 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or within 24 hours a To the Funeral L 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) PHYSICIAN D0064533 02.24-2009 30. Nance and address of person who completed cause of death (Item 23a) (Type, Print) CITRIATRIC

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Mon M, Day, Year)

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2434 W. BELVEDERE

BOTTIMORE MOZIZIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last), 2. Date of Death Month Physician 700 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Miriotori Marriote 5201 CARROLL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 16 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F 79 Yrs 179-22-5991 1929 PA Director July Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It world?! Examiner must be notified at MD Carroll Marriottsville 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21104 USA 7207 Marriottsville Rd. #2 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) banking account representative Health and Mental Hygir tem 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Maurice Peppelman Lillian Rosenberg ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages I care.
Department of Health an Important: If item 27 is 7207 Marriottsville Rd. #2, Marriottsville, MD 21104 Judi Van Parys (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State All County Cremation 2-27-09 Svkesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Daigippinght oferbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) **Physician** aL /Medical Due to as a consequence of): **Examiner** OUGL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ned by the attending physician detached for use as the buria Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an has autopsy performed? Yes 2 No this certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

filled in by the funeral director, within 24 hours after death.

To the Funeral Director: After

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature/and title of certified



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

09-01086 Mar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physician: r this certific ral director,		examiner? 1XX Yes 2 □ No	Hospital: 1 ☐ Inpati	ient 2 🗆	ER/Outpatient	t 3 DOA Oth		ome 5 Resid		Other (Specific	14.000 €
0	nding Physician: th. : After this certifica ? funeral director, p	L.	27. Manner of Death	28a. Date of Inj (Month, Da	ury	28b. Time of Injury	28c. Inju		28d. Describe h			Friend
Ö	Attending For death. ector: After by the funera	랿	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		ay, rear)	injury		Yes 2 □No				
UNISION	er de recto by tf	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	jury - At ho	ome, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and N	lumber or Rural	Route Number,
5	Ital or us aft ral Di led in											
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exan	ysician: To the best niner: On the basis	of examina	wledge, death ition and/or inv	occurred at the ti estigation, in my	me, date and place ppinion, death occu	, and due to the or rred at the time, o	ause(s) an late and pla	nd manner as sta ace, and due to	ated. the cause(s)
	o the //ithin //o the omple	Mec	29b. Signature and title of certifier	and manner st	Idled.	a all de	29c. Licens	e number	2		igned (Month, D	Pay, Year)
	F>F0		Melelin	px).		200	1 D	060:	54	=	2/9/	9
	1		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type, F	Print)	- 0	•		, , ,	t
	5w		William P	Dont		mo	609	5 Am	erica	5	2103	5
	Stat		31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ture						
	Registra	ar	FEB 1 1 2009	2	6	1						

			For State		State o	of Maryla	nd / Dep				and M			2009	06214	
		1. Decedent's Name (First, Middle, Last) 2. Date of Death									3. Time of Death					
	Physici /Medi		Carole Bush									Month 2	13 ^{Day}		4:40 A M	
, ;	Examir	ner	4a. Facility Name (If not institution, give street and number) 7 Bayou Ct.							Location o Pines				County of Death Orceste		
	Funeral		5. Social Security N	umber 6	. Sex 1 □ M 2 🛣 F		s. last birthday)	If Under Months		If Under 2		8. Date of Birtl (Month Day			place (State or Foreign	
	Director		216 45 25 Usual Residence of		1 L M 2LAF	44	Yrs.	WOTKIIS	Days	riodio		10/10/	1964	Scot	land	
	ryland ihow	_	10a. State	10b. County		10c. 0	City, Town or Lo	ocation							10d. Inside City Limits	
	he Ma 28a-f s	ecto	MD 10e. Street and Nun	Worce	ster	0 c	ean Pir	_	0-1-				10 000	(11/2) 0	1 □ Yes 2 No	
	ath with the Marylan 23a or 28a-f show ust be notified at	Funeral Director	7 Bayou					10f. Zip	218:	1			rog. Citiz	zen of What Cou USA	intry?	
	r death	uner	11. Marital Status		Armed Fo		U.S. 13.		ent of H	ispanic Orio	gin? (Spec	cify Yes or No- Rican, etc.)	1	14. Race - Amer Black, White		
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Event the must be notified at	by Fi	1 ☐ Never Marri		d 1 ∐Yes If Yes, Gi Year or D	ive		1 □Yes 2		Specify:	,	,		Specify: Whi		
21215-0036	72 hou natura Jical E	Completed by	(Spec	15. Decedent's			16a. Dece	dent's Usua	l Occup	ation	of working		16b. Kir	nd of Business/I	ndustry	
121	within ene.	mple	Elementary/Secon		College (1-4or 5+)	House	kind of work DO NOT use	e retirea)	Or WORKIN	9	Нот	nemaking		
	other rent, I	Be Co	17. Father's Name (st)		nouse	WIIC		18. Mother	r's Name	(First, Middle,				
ylar	ould be Menta arked atic ev	To B	Robert J	ohn Bro	vn					Mary	Mart	tin				
Mar	d 2 shouth and the and the shouth	0.4	19a. Informant's Na George B				1	_				Route Numbe		Town, State, Zi	ip Code)	
e,	os 1 an of Heal item 2	1	20a. Method of Disp	osition		20b.	Place of Dispo					ite		ation - City or T	own, State	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after de Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, I'm Mudcal Everness. once.		1 ☐ Burial 2 a 4 ☐ Donation		☐ Removal from cify)	State Ca	pe Hen	lopen	Cre	kford,	DE					
Ball	permit Depar Import any in		21. Signature of Fu	neral Service Li	ensee	2.		2. Name and			Du	rbage F rlin. M	uner 1D 21	neral Home 21811		
			23a. Part 1. Enter the shock, or hear	e disease, or co t failure. List or	omplications that only one cause on e	caused the dea									Approximate Interval Between	
	Physician /Medical		Immediate Cause (disease or condition resulting in death)	Final 1	-aMct	ostatic	Breast	Cauce	1						Onset and Death	
	Examiner				Due to	(or as a conse	equence of);									
	ed sit	iner	Sequentially list con cause. Enter Under Cause (Disease or i that initiated events	ditions, rediate lying	Dus to	(or as a nones	quenne of):									
,	execut n and al-tran	Examiner	that initiated events resulting in death) L	ast	c	(or as a conse	quence of):					<u>-</u>				
68760,	ficate be executed physician and s the burial-transit	edical			d											
39 x	eath certifica attending pl	/Med	IF FEMALE:		22a Huno out	toome of progr	nanav						\top			
Box	death of attended for us	Physician/Me	23b. Was decedent in the past 12 1 □ Yes 2	pregnant penths?		tcome of pregi birth 2□Fe nant at time of	tal death 3[☐ Ectopic pre☐ Other (spe					2	3d. Date of delive Month	very Day Year	
P.O.	at the o	hysi	9 Unknown	UNO	9 □ Unkr		111	(
Vital Records,	Physician; The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	by	Part II. Other signifi	cant condition	contributing to de	eath but not re	sulting in the u	nderlying car	use give	en in Part I.			baccous es 2 ⊑		the cause of death? bably 4 Unknown	
oce	e law requir has been s e 2 should	Completed										24a. Was a		24b. Were auto	opsy findings available	
a B	ician; The I certificate ha ector, page		autopsy performed? death? 1 □ Yes 2 No 1 □ Yes 2 No 1 □ Yes 2													
Vit.	ysician; lis certific director,	o Be	25. Was case referrence examiner? 1 ☐ Yes 2 🔀	-	Hospital:	Innationt 2 F	☐ ER/Outpatier	st 2□ DO/	Othe			(Check only on		☐Other (Speci		
n of	ding Phy h. After thi funeral c	on: To	27. Manner of Death		28a. Date		28b. Time of					3d. Describe ho			fy)	
Division	ttendi death. stor: A the fu	Certification:	2 ☐ Accident 3 ☐ Suicide	investigat	on			M	1 🗆 \	res 2□N		N. 1 1 10				
Οį	al or A s after Il Direct d in by	ertif	4 Homicide	determine	buildi	ng, etc. (Spec	home, farm, str sify)	eer, ractory,	onice		20	City or Town	reet and n, State)	Number or Hur	al Route Number,	
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Medical C	29a. Certifier (Check only one)	Certifying Medical Ex	Physician: To the aminer: On the b and man	best of my kr asis of examir ner stated.	nowledge, deat nation and/or in	h occurred a vestigation,	it the tin	ne, date and pinion, deat	d place, ar h occurre	nd due to the c d at the time, d	ause(s)	and manner as place, and due t	stated. o the cause(s)	
	To the within To the comp	Me	29b. Signature and t		(1.1. 1000					number		2	9d. Date	signed (Month,	Day, Year)	
			► ung		ulis MD					66160			2	13109		
F	3A5		30. Name and addre	ss of person wh	o completed caus	se of death (Ite 45 Old (em 23a) (Type, XCAU Cit	n Blud	#1	Bert	in in	40 218	11			
	Sta Registra	_	31. Date filed (Mont)	n, Day, Year)	32. R	egistrar's Sign	em 23a) (Type, Occau Cit nature	4.1	-		1					
	negistr	aı	1 6 6	1 1 U ZU	10 send	m p	· Mari	Service Control								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Amend Item 31 State of Mary State Registrar WCHD/SH 2/18/09 per VR Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Esther Physician Marie Brennan Day Vear Month Februar 01:06 AM /Medical 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington County Hospital Hagerstown Washington Social Security Number 217-42-9875 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 3-1-1943 6. Sex **Funeral** 9. Birthplace (State or Foreign Days Hours Min Director ClearSpringMD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location or items 23a or 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at MD Washington Clear Spring Director Y☐Yes 2☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Brennan Drive P.O.BOX 23 21722 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No 2 Specify: 3 ₩ Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than credit company Elementary/Secondary (0-12) College (1-4or 5+) Fraud analyst <u>12th grade</u> 0 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic even once. Lavena Tosten Ernest Trumpower ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tara Ortiz daughter Brennan Dr. Clear Spring, MD 21722 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Paul Cemetery 20a. Method of Disposition Feb 20. 20c. Location - City or Town, State 1 DBurial 2 Cremation 3 Removal from State Clear SpringMD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald Edwin Thompson Funeral Home, Inc Kellon. or composations the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or commutations that caused the shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final avel disease or condition resulting in death) Cerebral Due to (or as a consequence of): mom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed 1 aba physician and the burial-trans Due to (or as a consequence of)

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

or Attending Physician:

To the Hospital within 24 hours a To the Funeral L

Physician/Medical attending p been signed by the should be detached Completed by cate has page 2 s director, Be Certification: To funeral ours after death.

neral Director: A
filled in by the fu Medical

certificate

After this

IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 DNo 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1060796 02/17

SH-8

State Registrar

FEB 18 FEB 12 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MURSHED



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w 0

RID

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day LUCILLE COLEMAN ebrus 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washer ort s tow HOS 6. Sex 5. Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth 08/25/1943 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Months Days 1 □ M 2 □ E Hours CHÉRÁW, SC 247-72-9006 65 Yrs Usual Residence of Decedent MD State 10b. County Prince Georges 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No TEMPLE HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25th Avenue 20748 4114 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 years Procurement Agent Fed. Gov't 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isiah Fair Katie Baskins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4114 25th Avenue; Temple Hills, MD. 20748 Maciste A. Coleman - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Resurrection Cemetery 02/18/2009 Clinton, MD. 4 ☐ Donatton 5 ☐ Other (Specify) Signature of Fune 22. Name and Address of Facility Freeman Funeral Service 4594 Beech Road; Temple Hills, MD. 20748 Part 1. Enter the disease, or complications that caused the death. chock or heart failure. List only que a se on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate cause (Final disease or condition resulting in death) 4 therosel Cardiovas a Due to (or as a consequence of): Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death ☐ Pregnant at time of death b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 ☐ Unknown rt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2-No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year)

Physician /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

or items 23a or

'natural'

t of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, In M.

permit. Pages 1 and: Department of Health Important: If item 27 any injury or other tr once.

Director

Funeral

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Completed

Be ၉

event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-trar

Examir ā Con Be

physician the attending pl certificate has been signed by the rector, page 2 should be detached within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760,

Medic	IF
ysician	23
by Ph	Par
pleted	_

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

Certification: To

Medical

/6

State

DHMH 17 Rev 1/2001

27. Manner of Death

9 Unknown

5 ☐ Pending investigation

6 Could not be determined

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day,

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 8 2009 Lucille Coates 0650 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Seasons Hospice Baltimore Baltimore 7. Age (In yrs. last birthday)
60 Yrs.

60 Yrs.

60 Yrs.

60 Yrs.

60 Yrs.

60 Yrs.

10c. City, Town or Location

9. Birthplace (State or Foreign Country)
Maryland

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐Yes 2X No

^{Year)}948

USA

Race - American Indian, Black, White, etc.

Specify: Black

23d. Date of delivery

Dav

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Year

Month

8/09.

Physician /Medical Examiner

5. Social Security Number

10a. State

214-46-0587

Usual Residence of Decedent

10b. County

Funeral Director show

is 23a or 28a-f show 7 Is marked other than "natural", or items traumatic event, the Medical Experience or

attending p for use as signed by the a cate has I page 2 s certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Maryland Anne Arundel Pasadena Director with the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7840 Kings Bench Place 21122 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, It. Mode. once. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10th Nursing Assistant Assisted Living 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James A. Harris Mary Bell Simms 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Bell Simms (Mother) 92 Clay St. Annapolis, Md. 21401 20a. Method of Disposition 20b. PIB eaplings in Alame of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial Park 2-13-09 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Miniame Revenues of Scill ons Mortuary, F.A. 821 West St. Annapolis, Md. 21401 avry 13, Teese MODY 83 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic **Physician** tonsillar cuncer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ Wo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed autopsy performed 1 □Yes 2 ŪMo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 2 100 Medical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Many r of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

> 31. Date filed (Month, Day, Year) 32. Registrar's Signature

25 Main St, Suite 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

115 Karapalmene

N.S Rajapakse MD

Registrar

DO057465

Reisterstown, MD. 21136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2/5/2009 Ann Marie Dix 242 am^M /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🙀 F 227-50-1004 Director 67 10/22/1941 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f shov r than "natural", or items 23a or 28a-f show 1 XYes 2 ☐ No Director VA Danville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 130 Colonial Court Apt 42 24540 <u>USA</u> Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 □Yes 2₩No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: White ≥ 3 ☐ Widowed 4 🖾 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 0wner Apartment Rental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Allen Dix Katherine Burnett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is in any injury or other traum once. Angelia Baldwin Daughter 1924 Churchview Ct. Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/11/2009 Danville, VA Highlands Burial Pk 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sevene **Physician** physema disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transi resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 □No 1 □Yes al or Attending Physician; s after death.
I Director: After this certificate in by the funeral director, p Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mannet of Death 28h. Time of 28d. Describe how injury occurred 5 Pending investigation 1 - atural 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

State

completely

29a. Certifier

31. Date filed

(Check only one)

29b Signature and title of certifier

arme-and address of person who

OUW & MI

Medical

To the Hospital within 24 hours a To the Funeral C

DHMH 17 Rev 1/2001

Registrar

and manner stated.

cause of death (Item 23a) (Type, Print)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

200058297

Anne Arundel Medial Conta Annapolis MD 21401

29d. Date signed (Month, Day, Year)

			State of Maryland / Depa	artment of Health and M rtificate of Death	ental Hygie	ne No.2009	06219
			Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medi		Patricia Ann DICKERHOFF		February	15, 2009	10:30 M
,	Examir	er	4a. Facility Name (If not institution, give street and number) 902 W. Irvin Avenue	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Hagerstown If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	Washing	lace (State or Foreign
	Director		212 50 9934 1□M 2対F 60 Yrs.	Months Days Hours Min.	June 24 ,	1948 Mai	ryland
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation		1	0d. Inside City Limits
	Mary a-f sh	ţċ	Maryland Washington Hag	gerstown			1⊠Yes 2□No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?
	sath w		902 W. Irvin Avenue	21740	-16.34	USA	
ယ	be filed within 72 hours after death with the Maryland tial Hygiene. ed other than "natural", or items 23a or 28a-f show event, if a Modical Examinar must be notified at	Funeral	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🔀 No	Vas Decedent of Hispanic Origin? (Sper f Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	14. Race - Americ Black, White, e	
ğ	ours a rral", o	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	☐Yes 2☐No Specify:		Specify: wh	nite
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212	d withi	Completed	College (1-4015+)	assistant		church	
Maryland 21215-0036	tal Hygi d other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name		,	
yla	should be filed withir and Mental Hygiene. s marked other than umatic event, tre the	ပ္	John Lewis Spigler Sr.		lizabeth		
	s 1 and 2 should of Health and Mer item 27 is marke other traumatic			g Address (Street and Number or Rural B Woodlands Run, Ha			
e,	of Hea		20a. Method of Disposition 20b. Place of Dispos			Location - City or To	
altimore,	Pages ment of tant: If its lury or o		igg burial 2 Li Cremation 3 Li Removal from State	n Mem. Park 2/20/	09 Ha	gerstown,	Maryland
Ball	permit. Pages Department of Important: If it any injury or o	ij	- The strong of			NERAL HOME	
			23a, Part 1. Enter the disease, or complications that caused the death. Do not enter	5 E. Wilson Blvd.,	Hagerstory arrest	own, Maryl	and 21740 Approximate
	Physician	1	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	recit (mic			3 months
	LAdillilei	į.	Sequentially list conditions, if any, leading to immediate b				
	cuted Id ansit	Examiner	Cause: Chief Underlying Cause (Disease or injury that initiated events				
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09/80	ifficate be executed g physician and as the burial-transit	edical	d				
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o D	requires that the death cer een signed by the attendin nould be detached for use	Physician/M	in the past 12 months? 1 Yes 2 No 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 0 Linkson at time of death 5	Other (specify)			Day Year
7.	hat the		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I	23e Did tohace	co use contribute to th	o cause of death?
vital Mecords,	uires t n signe Id be o	d by	The district resulting in the district resul	deriying cause given in Part I.	TO .	2 ☑ No 3 ☐ Prob	
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ř	The I	Completed			autopsy performed 1 🗆 Yes 2 🗗	? death?	npletion of cause of
V Ita	sician: certific rector,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death	(Check only one)		
0	y Physer this eral dii	٦ ا	27. Manner of Death 28a. Date of Injury 28b. Time of		e 5 🖫 Residence 3d. Describe how in	e 6 ☐ Other (Specify)
VISION OT	auth. or: Aftu	atio	1 ☑Natural 5 □ Pending (Month, Ďay, Year) Injury 2 □ Accident investigation	28c. Injury at Work? M 1 Yes 2 No		,,	
<u> </u>	or Atta	Certification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	Bf. Location (Street City or Town, St	and Number or Rural	Route Number,
_	spital ours a neral f		29a. Certifier 1. ertifying Physician: To the best of my knowledge, death	occurred at the time, date and place, a	nd due to the cause	e(s) and manner as st	ated
	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or inventor and manner stated.	estigation, in my opinion, death occurred	d at the time, date	and place, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	29c. License number	1	Date signed (Month, L	
		1	Muchael Mulound MD	041667		1.17.0	2 4
3	4-8		30. Name and address of person who completed cause of death (Item 23a) (Type, P. Michael McCormack ////0	rint) Nedfect (vi	naus	1de c = 2. 2.	no mo
F	Stat	-	or. Date filed (Morial, Day, Tear)	37 20(1001 207	7	100 (-110	
	Registra	ir	FEB 18 2009 Denum A. Sa	Res .			

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State Registrar

DR. GHAZALA QADIR 31. Date filed (Month

32. Reistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713 301 432

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1045 **Physician** QUERRA UGUST 9)2 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6703 23rd Avenue Hyattsville Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 8/15/1969 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days _ M 2□F 39 Guatemala none Yrs. **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Prince George' Hyattsville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23rd Avenue 6703 20782 Guatemala Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married ¹⊠Yes 2□No *Specify:* Guatemalan Baltimore, Maryland 21215-0036 Specify: ģ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Roof contractor construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown Maria Luisa Guerra ဂ္ friend 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda Lorena Sagastume/ 6703 23rd Avenue Hyattsville, Maryland20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation **/**5 ☐ Other (Specify) Chiquimula, Guatemala Municipal Cem. 2/18/2009 meral Service License PHITTPANDS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 21, Signature 23a. Part 1. Enter the diserte, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CastomacH **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy n the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate funeral director, pag 2 No 1 Yes 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) ပ္ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation n 24 hours after death.

e Funeral Director; A

bletely filled in by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical and manner stated. To the I within 2 29b. Signature and title of certifie M. D.

Registrar DHMH 17 Rev 1/2001

State

CHAR 31. Date filed (Month, Day, Year) MEHWAY

445

Name and address of person who completed cause of death (Item 234) (Type, Print) J. LaKENTA un

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 62 100PM Dolores P. Gessig /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hzens Nursing Harford Home DE Grace Social Security Number Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Min Director 206-16-0132 83 Jan. 1. 1926 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director □Yes 2□No Maryland Harkord Havre de Grace 10e. Street and Number 10g. Citizen of What Country? 707 St. James Terrace 21078 Completed by Funeral U.S.A. Was Decedent Ever in U.S. Armed Forces 1 | Yes 2 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes XXWidowed 4 □ Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaker 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) John Sieklicki ဥ Alexandra Kibitlewski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonny Harvey - Daughter 707 St. James Terrace, Havre de Grace, Maryland 21078 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. R.A. Ferris & Company 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 02-23-2009 West Chester, P.A. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lettman Funerat Home, 123 S. Washington St. Havre de Grace, ro of Funeral Servi MD. 21078 23a. Part1. Enter the disease shock, or heart fallere. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Demention /Medical Due to (or as a consequence of): Examiner antensim Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or is consequence of) attending physician and for use as the burial-transit mma Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 🔏 🖾 No 3 ☐Ectopic pregnancy 4☐Pregnant at time of death Month Day Year signed by the a d be detached for 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably cate has I page 2 s After this certificate funeral director, Be ပ Certification:

76519 Dolotes ρ Division of Vital Records, P.O. Box 68760,

hin 24 hours after death the Funeral Director: filled in by the ö Hospital

05 W				24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	☐ER/Outpatient 3☐[044	
27. Man of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
4 Homicide determined		nome, farm, street, factorify)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 (Check only one) (Check only one) 1 ✓ Certifying P 2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occu	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

31. Date filed (Month) Para

29c. License number 6

29d. Date signed (Month, Day, Year)

M.n. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 35

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State Registrar

Medical

within 24

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		S	tate of M	larylar		artment of l rtificate of		nd Mental H	lygien Reg. N		a n	6223
	Physici /Medio		1. Decedent's Name		lle, Last) eorge	:S		Guira	agoss		2. Date of I Month Febru	Death D	Oay Ye	3. Ti	me of Death 46 p ^M
1	Examir		4a. Facility Name (I Laurel 5. Social Security N	Regic	on, give stre	Hospi	tal ge (In yrs.	last birthday)	4b. City, Town, o Laurel If Under 1 Year	If Under 24	Death Hrs. 8, Date of J	P:	c. County of D	Georg	
	Director		592-96-9 Usual Residence of		1 □ M	2 🕅 F	72	Yrs.	Months Days	Hours	Min. 1 2/1/9	736		ebanoi	
	er death with the Maryland items 23a or 28a-f show iter instite notified at	tor	10a. State	10b. County Howar			10c. Cit	ty, Town or Lo	cation	1					de City Limits Yes 2 □ No
	r 28a	irec	10e. Street and Nur		. u		Dau.	rer	10f. Zip Code			10g. C	Citizen of Wha	it Country?	
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036	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Exartites rust be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		ried	Was Decedent Armed Forces 1	?] No		Was Decedent of I f Yes, specify Cub 1 □Yes 2 No	Hispanic Origin an, Mexican, F Specify:	o? (Specify Yes or I Puerto Rican, etc.)	No-	Błack, V	American India Vhite, etc. ebanes	
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Baltimore,	permit. Pages Department of Important: If its any injury or o		1 □ Burial 2 □ 4 □ Donation	Cremation	3 □ Remo Specify)	oval from State	Ga	remetery, cren ce of cemete	natory or other pla Heaven Ery	ce) 2/	17/09	Silv	ver Sr	oring.	MD
Ball	permit Depar Impor any in		21. Signature of Fu	neral Service	Licensee	sca:	TONK	^ 22	. Name and Addre	ess of FacilityB	riscoe- ngton R	Toni	ic Fur	neral	Home
	Physician		Immediate Cause (Final	complication control	ons that cause ause on each li	d the death	h. Do not ente	er the mode of dyi	ng, such as ca	rdiac or respiratory	arrest,		Approx Interva Onset	rimate Il Between and Death
	/Medical Examiner		disease or condition resulting in death)	1	a . –	Due to (or as	a consequ		ardial	Intard	ction			1 hc	our
	ed sit	iner	Sequentially list cor if any, leading to im- cause. Linter Under Cause (Disease or i that initiated events	iditions, mediate	b	Due to (or as	a consequ	uence of):							
o,	icate be executed physician and the burial-transit	ũ	Cause (Disease or i that initiated events resulting in death) L	njury .ast	c	Due to (or as	a consequ	uence of):							
68760,	tificate be executed g physician and as the burial-transit	edical			d										
.O. Box	eath cer attendin for use	by Physician/M	IF FEMALE: 23b. Was decedent in the past 121 1 ☐ Yes 2X 9 ☐ Unknown	months?		f yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	Ideath 3□	Ectopic pregnand Other (specify)	у			23d. Date of Month	delivery Day	Year
rds, P.	w requires that the d been signed by the should be detached	ed by Pł	Part II. Other signifi Dementi		ons contribu	iting to death b	out not resu	ulting in the un	derlying cause giv	en in Part I.				e to the cause	
Division of Vital Records,	ician: The law re certificate has be ector, page 2 sho	Completed					·····				24a. Wa aut per 1 □ Yes	opsy formed?	prior death	autopsy findi to completion h? Yes 2 □ No	of cause of
Zita Zita	sician certifi rector,	Be	25. Was case referre		Hospi	ital:			Oth		Death (Check only				
ion of	Attending Physician: The sr death. ector: After this certificate h by the funeral director, page	ition: To	1 ☐ Yes 2 🔏 I 27. Manner of Death 1 ☑ Natural 2 ☐ Accident		2	1 ☐ Inpation 8a. Date of Inju (Month, Date)	ury	ER/Outpatient 28b. Time of Injury	28c. Injur Worl	y at	28d. Describe			Specify)	
Divis	tal or Atters safter des al Director ed in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could in determine		8e. Place of Inj building, et	ury - At ho c. (Specify	me, farm, stre	et, factory, office		28f. Location City or To	(Street ar	nd Number or e)	r Rural Route	Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)	Certifying Medical	Examiner:	n: To the best On the basis o and manner st	of examinat	wledge, death tion and/or inv	occurred at the tile estigation, in my c	me, date and p pinion, death o	lace, and due to the	e cause(s e, date an	s) and manne od place, and	er as stated. due to the cau	se(s)
	Vithir Comp	Me	29b. Signature and t	itle of certifier	1		-3		29c. Licens					onth, Day, Yea	
	,/	-	30. Name and addre	m	4 (Lens	12	000) (T		296	6	Febr	uary	11,20	09
_	7	ŗ	Thomas H 31 Date filed (Month)	• Bur	wno comple quie:	red cause of d	iesh (Item ID 73	23a) (Type, F	rint)	Des 3	T	MD	2070	7	
	Stat	е	on bate med (mon	i, Day, Tear)		32. Registr			Dusei	LKOAd	<u> </u>	, UU	2070	/	
	* Registra	ar _	FFR17	2009	Bow	w M.	1476	Con							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 2009 Frankie Gladden February 7:40 P^{M} 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery General Hospital Olney Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1**M** 2□ F Months Days Hours Min. 578-48-9831 72 Jan 21. 1937 Washington, DC Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Montgomery 1X Yes 2 ☐ No Brookeville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18716 Tanterra Way 20833 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: 3 Nidowed 4 Divorced African American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 years Elementary/Secondary (0-12) Personnel Analyst Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Gladden Nancie Hemphill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wenona Gladden-Ford / Daughter 11736 Othello Terrace Germantown, MD 20876 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other of 20c. Location - City or Town, State Date t Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l Cemt. Feb 26, 2009 Arlington, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Vic 4001 Benning Road, NE Washington, DC 20019 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erebral Vascular Due to (or as a consequence of): iration Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown

Physician /Medical Examiner

permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau once.

Physician

/Medical

Director

Funeral

þ

Completed

Be

2

10a. State

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Experimentments to a citized at

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed Anous after death.

Anound after death.

Anound after does this certificate has been signed by the attending physician and stelly filled in by the funerial director. Agree this certificate has been deathed for use as the burial-transit stelly filled in by the funerial director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Examine Physician/Medical Š Completed Be Certification: To

Part II. Other significant conditions	contributing to death but not resulting in the underlying 😭	ause given in Part !.	23e. Did tobacco use contribute to the cause of death?
Coronary art	ery disease, Atrial	1 Yes 2 No 3 Probably 4 Unknown	
Chronic Kidne	y disease, Hyperten	Sim	24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of Death ((Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DO	A Other: 4 Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury	Bc. Injury at Work? 1 ☐ Yes 2 ☐ No	3d. Describe how injury occurred
3 Suicide 6 Could not be determined		office 28	If. Location (Street and Number or Rural Route Number, City or Town, State)
	nysician: To the best of my knowledge, death occurred		

24 hours a

State Registrar

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mont

and manner stated

29d. Date signed (Month, Day, Year) -200

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		for State Registrar	State of Maryla		artment of H tificate of L			giene Reg. No.	0000	06225
Physic		1. Decedent's Name (First, Middle, Last	S.	61	DVE		2. Date of De Month	ath Day		3. Time of Death 1935 M
/Med Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deatl			County of Deatl	
		The Johns Hopkins Ho	spital		Baltimore	City				
Funeral Director	_	5. Social Security Number 6. Se 219-76-8576	7. Age (In yr 50	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	y, Year)	9. Birtl Cou ,1958 Tak	nplace (State or Foreign intry) coma Park, MD
rland now		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits
Man a-f sh	ctor	Maryland Prince Ge	orge's Ne	w Carro	11ton					1 X Yes 2 □ No
th the or 28 e noti	Directo	10e. Street and Number		_	10f. Zip-Code			10g. Citi	zen of What Cou	intry?
ath w s 23a rust b	ra	7609 Fontainebleau				0784			SA	
ie, intallylation Z IZ IS-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. tiem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 🎛 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🎛 No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		14. Race - Amer Black, White Specify: 1,1	
2 hour		15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation	atria -	16b. K	ind of Business/	
ithin 7 e. an "n Medi	ompleted	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	iire.	kind of work done of DO NOT use retired,)	rking	_		
led w lygien her th	U	17. Father's Name (First, Middle, Last)		EI	ectrician		me (First, Middle		ntracto	<u>-</u>
Lalylation C. I.C. Should be filed within and Mental Hygiene. is marked other than aumatic event, the Mental C.	To Be	Donald E. Giove					.1en Ben		Surriame)	
2 should and Men is marke	-	19a. Informant's Name/Relationship (T)	pe. Print)	19b. Maili	ng Address (Street a	and Number or R	ural Route Numb	er, City o	or Town, State, Z	ip Code)
E, INICAL LAND 2 Health a tem 27 is other train		Beth Giove / Wife		7609	Fontaineble	au Drive,	#2212, No	ew Car	rollton,	MD 20784
permit. Pages 1 and 2 Department of Health a Important: If item 27 i any injury or other tra once.		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗔 4 🗆 Donation 5 🗀 Other (Specify)	Removal from State	cemetery, cre.	osition (Name of matory or other place Cemetery		Date 1/2009		rel, Mai	
permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licens	Manage	1	2. Name and Addres	-	me, P.A.	473 Hya	9 Balti ttsvill	more Avenue e, MD 20781
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	ications that caused the de ne cause on each line.	ath. Do not en	er the mode of dyin	g, such as cardia	c or respiratory a	irrest,		Approximate Interval Between
Physician /Medical	ì	Immediate Cause (Final disease or condition resulting in death)	a. Gastro In Due to (or as a cons	esh no	e ble	ecl				onset and Death
Examiner	ē.	Sequentially list conditions,	Liver	faile	ure .		•			one year
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ificate be executed physician and as the burial-transit	ledical	L	Hepatit	is ($\frac{1}{2}$	irus				ten years
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3	☐ Ectopic pregnancy ☐ Other (specify)	1		2	23d. Date of deli Month	very Day Year
uires that t signed by	by P	Part II. Other significant conditions co	ntributing to death but not i	resulting in the	underlying cause giv	ven in Part I.	23e. Did t	,	use contribute to	the cause of death?
he law req has been age 2 shou	Completed							osy rmed?	prior to death?	copsy findings available completion of cause of
sician: Th certificate lirector, pa	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o		Tes	2 No
nysici nis cer	일	1 ☐ Yes 2 No		☐ ER/Outpatier	t 3 DOA Othe	er: 4 \square Nursing H	ome 5 🗆 Resid	dence (6 ☐ Other (Spec	ify)
Ing Pt		27. Manner of Cearn 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work	?	28d. Describe I	how injur	y occurred	
vittend death death stor: /	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At	home, farm, str		/es 2 □ No	28f. Location (Street an	d Number or Ru	ral Route Number,
al or A s after il Dire	Certification:	4 Homicide determined	building, etc. (Spec	cify)			City or Tou			,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier (check only one) Certifying Phy	sician: To the best of my kr ner: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the tim vestigation, in my of	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) date and	and manner as d place, and due	stated. to the cause(s)
To the comp	Ž	29b. Signature and title of certifier	Δ. 1.	1	29c. License			29d. Dat	e signed (Month	, Day, Year)
. 1		Trenda Ham	M, Medical	docto	1 RES	-000	2 1	rebri	vary 13	, 2009
R		30. Name and address of person who c	ompleted cause of death (If	tem 23a) (Type,	Print)	600	North Wo	lfe S	/ t, Baltimo	re, MD, 21287
St Regis	ate rar	31. Date filed (Month, Day, Year) FEB 1 7 2009	32. Registrar's Sign	nature						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 17,19ab per hosp. g888 2/27/08 kh
Certificate of Death

Reg. NO. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month KILEY GUINAN 04:21 AM 02 200 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST MONTGOMERY KOCKVILLE, MARYLAND HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, O.2. - O.8) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year 1 □ M 2 🗙 F Director NONE MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Menlal Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f shov Lry or other traumatic event, the Medical Examiner must be notified at GERMANTOWN, 1 Yes 2 □ No Director MONTGOMERY MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RIDGE 24101 ROAD 20876 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFANT 17. Father's Name (First, Middle, Last) unknown 18. Mother's Name (First, Middle, Maiden Surname) Be GRACE မ 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
24101 Ridge Rd., germantown, MD 20876 19a Informant's Name/Relationship (Type. Print)
Kirsten Guinan mother permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is any Injury or other trau once. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 03-09-2009 HALL RIVER, NC 4 □ Donation 5 ☐ Other (Specify) CYCLE 21. Signature o Fune Il Service Licensee 22. Name and Address of Facility 9901 MEDICAL CENTER DRIVE, ROCKVIIK, MD20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PREMATURIT **Physician** XTREME /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending nanalysis and bunal-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Be Completed 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) the funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0066695 9 Jayarray 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND 20850 JAYARAJ, MD. SUJITHRA

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

	1	State Registrar		Ce	ertificate of Deat		Reg. No. 2005	
ian ical	ľ	David Patrick Gav				2. Date of Dea Month February	Day 19, 2009	3. Time of Dea 1:00 1
ner	4	a. Facility Name (If not institution, g			4b. City, Town, or Location		4c. County of Death	
	5	4607 Feldspar Road Social Security Number 6.		e (In yrs. last birthday	Middleto			erick place (State or Fo
		186-42-1252	1√ M 2□ F	59 Yrs.	Months Days Hour		y, Year) Coul 0, 1949 Per	ntry) nsylvani
	1	0a. State 10b. County		10c. City, Town or L	ocation		1	0d. Inside City Li
Director	1	Maryland Frede	erick		Middletown			1 ☐ Yes 2 万
		0e. Street and Number 4607 Feldspa:	r Poad		10f. Zip Code 21769		10g. Citizen of What Cour	
Funeral	-	1. Marital Status	12. Was Decedent I	Ever in U.S. 13		Origin? (Specify Yes or No-	U.S.A.	
2		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	1970- 1990	. Was Decedent of Hispanic If Yes, specify Cuban, Mexi 1 ☐ Yes 2 ☑ No Spec		Specify:	
sted		15. Decedent's (Specify only highest g	Education	16a. Dec	edent's Usual Occupation	aget of working	16b. Kind of Business/In	dustry
Completed	- -	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	e kind of work done during rr DO NOT use retired) Engineer		Information	Technolo
		7. Father's Name (First, Middle, La	5+			ther's Name (First, Middle,		
To Be		Joseph V.	_			Margaret	E. Rieger	
-		19a. Informant's Name/Relationship		19b. Mai	ling Address (Street and Nur	mber or Rural Route Number	er, City or Town, State, Zip	Code)
			(Daughter)		Feldspar Roa		<u> </u>	
	2	10a. Method of Disposition 1 ☐ Burial 2√ Cremation 3	Removal from State		position (Name of ematory or other place)	February	20c. Location - City or To	
		4 □ Donation 5 □ Other (Spec	cify)		rg Crematory 22. Name and Address of Fa	23, 2009	Smithsburg,	
	1	21. Signature of Funeral Service Lic			12525 Bradbur	. о.н. ра	vis Funeral shura. Marul	
	<	222. Part 1. Enter the disease, or co	mplications that caused	the death. Do not e	nter the mode of dying, such			Approximate Interval Betwee
		shock, or heart failure. List on Immediate Cause (Final disease or condition		10. 11 51 cm	cloodend	C7-4120		Onset and Deat
		resulting in death)		a consequence of):	e o weer en		, , , , ,	7 5 7.0
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Exa		that initiated events resulting in death) Last	Due to (or as	a consequence of):				
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/Medica		F FEMALE:	23c If you outcome	of pregnancy			23d. Date of deliv Month	
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hysician/Medica		23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown		☐ Ectopic pregnancy ☐ Other (specify)			Day rea
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To Be Completed by		23b. Was decedent pregnant in the past 12 months? 1	1	at time of death 5 ut not resulting in the control 2 ER/Outpatiry 28b. Time	Underlying cause given in Pa	24a. Was autor period of the control	res 2 No 3 □ Prol an 24b. Were auto prior to co death? 1 □ Yes	he cause of death bably 4 Unking psy findings ava mpletion of caus
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Certification: To Be Completed by		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 25c. Was case referred to medical examiner? 1 Yes 2 No 27c. Manner of Death Natural 5 Pending investigate 1 Yes 2 Yes	Hospital: 28a. Date of Inju (Month, Da on be d 28e. Place of Inju building, etc.)	time of death 5 ut not resulting in the 2 ER/Outpati ry 28b. Time Injury ury At home, farm, so (Specify) of my knowledge, deaf examination and/or	Underlying cause given in Pa	24a. Was autop performed to the search of Death (Check only of the search of the searc	an sy 24b. Were autoprior to code ath? an language of the sy of t	he cause of death bably 4 Unkn basy findings avai mpletion of caus 2 No fy) al Route Number, stated.
To Be Completed by		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Part II. Other si	Hospital: 28a. Date of Injuic (Month, Date of Injuic) 28e. Place of Injuic)	at time of death 5 ut not resulting in the sent 2 ER/Outpatiry 28b. Time Injury 28b. Time (Specify) of my knowledge, def examination and/or ited.	Underlying cause given in Pa	24a. Was autor performed at the time, are	an sy rore autoprior to condend t	he cause of death bably 4 Unkn psy findings ava impletion of caus 2 No fy) al Route Number, stated, o the cause(s) Day, Year)
Certification: To Be Completed by		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Part II. Other si	Hospital: 28a. Date of Injuic (Month, Date of Injuic (Month) (Month, Date of Injuic (Month) (Mon	at time of death 5 ut not resulting in the sent 2 ER/Outpatiry 28b. Time Injury 28b. Time (Specify) of my knowledge, def examination and/or ited.	Underlying cause given in Pa	24a. Was autor performed at the time, are	an sy rore autoprior to condend t	he cause of deat bably 4 Unk opsy findings ava ampletion of caus 2 No fy) al Route Number stated. o the cause(s) Day, Year)
Certification: To Be Completed by		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Part II. Other si	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da 28e. Place of Inju bel display and manner st.)	at time of death 5 ut not resulting in the sent 2 ER/Outpatiry 28b. Time Injury 28b. Time (Specify) of my knowledge, def examination and/or ited.	Underlying cause given in Pa	24a. Was autor performed at the time, are	an sy rore autoprior to condend t	he cause of deat bably 4 Unk opsy findings ava ampletion of caus 2 No fy) al Route Number stated. o the cause(s) Day, Year)
Medical Certification: To Be Completed by		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 28a. Date of Injudicing, etc. 28e. Place of Injudicing, etc. Physician: To the best aminer: On the basis of and manner street.	at time of death 5 ut not resulting in the sent 2 ER/Outpati ry (Year) 28b. Time Injury ury - At home, farm, so (Specify) of my knowledge, der fexamination and/or ated.	underlying cause given in Pa 26. PI 26. PI ent 3 DOA Other: 4 O	24a. Was autor performed at the time, are	an sy rore autoprior to condend t	he cause of death bably 4 Unkr opsy findings avai impletion of cause 2 No fy) al Route Number, stated, o the cause(s) Day, Year)
Certification: To Be Completed by		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Part II. Other si	Hospital: 28a. Date of Injudicing, etc. 28e. Place of Injudicing, etc. Physician: To the best aminer: On the basis of and manner street.	at time of death 5 ut not resulting in the sent 2 ER/Outpatiry 28b. Time Injury 28b. Time (Specify) of my knowledge, def examination and/or ited.	underlying cause given in Pa 26. PI 26. PI ent 3 DOA Other: 4 O	24a. Was autor performed at the time, are	an sy rore autoprior to condend t	he cause of death bably 4 Unkn psy findings ava impletion of caus 2 No fy) al Route Number, stated, o the cause(s) Day, Year)

			For State Registrar	State of Maryland	-	artment of H			iene _{eg. No.} 2009	06228
			Decedent's Name (First, Middle, Las	1)				2. Date of Deat	h	3. Time of Death
	Physicia /Medic		Frederick D. Ha	arris Sr.				Februa	ry 7 200	9 3:30 P ^M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of D	eath	4c. County of Dea	
, and			Marley Neck Reb		£	Glen 1			Anne A	
	Funeral		5. Social Security Number 6. Security Number 113 - 22 - 2182		ast birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Birth Min. July 13	Year) 9. Bi	thplace (State or Foreign ountry) ryland
	Director		Usual Residence of Decedent		0 0 113.			QUIY 13	1323 114	
	land ow ≡		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary	호	Maryland Anne A	cundel P	asade	na				1 □Yes 2 No
	h the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
	hours after death with the Maryland tural", or frems 23a or 28a-f show al Examiner mast be multified at	Je,	899 Cool Spring	g Ave		21	122		USA	
	r dear	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin n, Mexican, P	? (Specify Yes or No- ruerto Rican, etc.)	14. Race - Am Black, Whi	
36	or it	by Fi	1 Never Married 2 Married	1 XYes 2 ☐ No If Yes, Give		1 □Yes 2 ▼ No	Specify:		Specify: B	lack
21215-0036	72 hours 'natural'; dical Exc		Widowed 4 ☐ Divorced 15. Decedent's Edi	Year or Dates: 1944		dent's Usual Occupa	ation		16b. Kind of Business	/Industry
Ċ	filed within 72 ho Hygiene. Sther than "naturent, ent, the Medical	Completed	(Specify only highest grad	de completed)	(Give	kind of work done o	luring most of	working	TOB. Time of Business	, moustry
212	withi jiene. r thar	E	Elementary/Secondary (0-12) 8th	College (1-4or 5+)	Т	ruck Dr	iver		City of	Annapolis
ס	filed Hyg Sthe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle, I		•
lar	Ald be Alental riked of tic ev	To B	Charles E. Harr	cis			Nar	ncy Brown		
	s 1 and 2 should to the Health and Men Item 27 is marker other traumatic		19a. Informant's Name/Relationship (7	ype. Print)	19b. Mailir	ng Address (Street a	and Number o	or Rural Route Number	, City or Town, State,	Zip Code)
	and 2 ealth a n 27 is		Frederick D. Har			9 Cool :				Md. 21122
ore	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐			sition (Name of natory or other place			20c. Location - City o	
altimore,	t. Pages tment of tant: If It ijury or o		4 Donation 5 Other (Specify		~	d Veter			Crownsvi	
Balt	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service Licen	see				ons Mortu	_	
ш_	20 E # 9		Javy & se	20eM00483				Annapolis		
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	dications that caused the death one cause on the line.	n. Do not ent	er the mode of dyin	g, such as ca	rdiac or respiratory arr	est,	Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Caedia	ac t	myltour	a.			
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	1				
		e.	Sequentially list conditions,	b. Due to for as a consequ	ience off:					
	nsit	nin.	Cause (Disease or injury	Due to (or as a consess	derice oil:					
	be executed ician and burial-transit	Examin	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):					
760	ate be executed hysician and the burial-transit	ical		d						
89	death certificate e attending phys d for use as the									
Вох	leath certific attending p for use as	N/	iF FEMALE: 23b. Was decedent pregnant	23c. if yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnancy	,		23d. Date of d	elivery
		sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of d		Other (specify)	·		Month	Day Year
Д. О.	at the de by the tached	Physician/Med	9 ☐ Unknown							
Ś	The law requires that the ate has been signed by thoage 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.			to the cause of death?
Records,	w requir been si should!	ted						1 \ Y	es 2 No 3 1	Probably # Unknown
ec	e law has b je 2 sh	nple						24a. Was a autops	sy prior to	utopsy findings available completion of cause of
		Completed						perform 1 □ Yes		s 2□No
Vita	Attending Physician: The Isr death. ector: After this certificate haby the funeral director, page?	Be	25. Was case referred to medical examiner?	Hospital:	V	Othe		Death (Check only on	e)	
ot	Phys this ral dir	은	1 ☐ Yes 2 ☐ No 27. Manper of Death	1 Inpatient 2 2	ER/Outpatier 28b. Time o	π 3 □ DOA	AlarNursi	ing Home 5 Reside	ence 6 Other (Sp ow injury occurred	ecify)
Division of	ng Tel	ioi	14 Natural 5 ☐ Pending	(Month, Day, Year)	Injury	Work	yat (? Yes 2 □ No		ow injury occurred	
2	deatl deatl ctor: y the	fical	3 Suicide 6 Could not be		ome, farm, str		103 2 110		treet and Number or H	Rural Route Number.
	after Dire	Certification:	4 Homicide determined	building, etc. (Specif	y)			City or Town		,
_	ne Hospital or Attendli n 24 hours after death. ne Funeral Director: A pletely filled in by the fu		29a. Certifier Certifying Ph	ysician: To the best of my kno	wledge, deat	h occurred at the tir	ne, date and	place, and due to the o	cause(s) and manner	as stated.
	To the Hospital or within 24 hours afte to the Funeral Dir completely filled in	Medical	(Check only and Medical Exam	niner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	pinion, death	occurred at the time, o	late and place, and di	ie to the cause(s)
	To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in b	N	29b. Signature and title of certifier			29c. License	e number	2	9d. Date signed (Mor	nth, Day, Year)
	1 22		1			D570	028	F	eb. 9, 8	2009
	/×.@		30. Name and address of person who	completed cause of death (Item	1 23a) (Type,	Print)		1		
	. A		Aditua Chop	ra 600 Ric	gely	Ave Si	H231	Annapa	us mo a	21401
	Sta Registr		31. Date filed (Month, Day, Year) FEB 112	32. Registrar's Signa	B. A	arked		Annapa		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month

Physician /Medical Examiner

2009 Richard Carl Harris February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Renaissance Gardens RC-1327 Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Mar. 29, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1 X M 2 □ F **Funeral** Director 396-12-4596 85 Iowa Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show if than "natural", or items 23a or 28a-f show the Medical Examiner must be rollfied at 1 ☐ Yes 2 No Director MD Prince George's Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 3160 Gracefield Road RC-1327 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 0 Maryland 21215-0036 1 ☐ Yes 2X No Specify: White ò Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) <u>Patent Attornev</u> Law Firm 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Carl Garland Harris Lois Eliza Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Cowell/daughter 1022 Old Turkey Point Rd. Edgewater, MD 21037 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 02/13/09 Odenton, MD Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Funeral Service Licens 23a. Part 1. Enter the desease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a Squamous Cell Carcinoma Facial year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dire to (or as a consequence of) requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p se esn IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. 1 TYes 2 No. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð Congestive Heart Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 1 ☐ Yes 2 🔏 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dire Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending investigation i Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 5 To the Hospital o within 24 hours aff To the Funeral DI 29a, Certifiei 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 12+1 D24035 02/12/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.S. Machado, M.D. 3110 Gracefield Rd. Silver Spring, MD 20904 31. Date filed (Monti istrar's Signature State

Registrar

MARKENA

		1	State of Maryland / Department	artment of Healtl		Hygiene Reg. No.2	009 06230
ı			1. Decedent's Name (First, Middle, Last)			of Death	3. Time of Death
	Physicia /Medic		Ruth E. Johnson		Febr	uary Day 1	l 2009 4:36A M
	Examin		4a. Facility Name (If not institution, give street and number) 1426 Regent St.	4b. City, Town, or Location			ounty of Death nne Arundel
	Funeral		5. Social Security Number 6. Sex $1 \square$ M $2 \square$ F 7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year If Und Months Days Hour	ider 24 Hrs. 8. Date	of Birth th, Day, Year) 13 191	9. Birthplace (State or Foreign Country) 15 Maryland
	Director	1	Usual Residence of Decedent		1102		
	should be filed within 72 hours after death with the Maryland ind Mental bylgiene. In marked other than "natural" or items 23a or 28a-f show marked other than "natural" or items 23a or 28a-f show umatic event, Ite Medical Evaning the notified at	_ 1	10a. State 10b. County 10c. City, Town or Lot 10a. State Annapol				10d. Inside City Limits 1X Yes 2 □ No
	the M	Directo	10e. Street and Number	10f. Zip Code		10g. Citize	n of What Country?
	3a or	Ö	1426 Regent St.	21403		Ţ	JSA
	ems 2	Funeral		Was Decedent of Hispanic If Yes, specify Cuban, Mex	o Origin? (Specify Yes	or No- 14	. Race - American Indian, Black, White, etc.
0000	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hyglene and the 23a or 28a-f show then 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, Its Madical Evaning must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 □Yes 2X No Spec			pecify: Black
5	72 hou	eted	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation	most of working	16b. Kind	of Business/Industry
7	/Ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during n DO NOT use retired)	moot of working	Dead	:t-a
V	filed w Hygle ther t		6th 0 I	Domestic 18. M	lother's Name (First, M		ivate
מומ	buld be filed with Mental Hyglene arked other than atic event, It and	To Be	Charles Thomas	Ge	orgianna	Snowde	n
Mary	2 shou and N and N is mai	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Nu		-	
Ž (n)	and 2 tealth m 27 her tr			2 Gate Dr.	Annapo		d. 21401 ation - City or Town, State
baitimore	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cation (Name of or other place) 1 Park	2-14-09		apolis, Md.
Dalt	permit. Departr Imports any inje			VinName Recesse of & 321 West St		_	
			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	iter the mode of dying, such	h as ca diac or respira	ntory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	for Kene	I bye	Sol	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	i Caldio,	vasules	Sus	e 1945
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)				
	ecuted and translt	Examine	that initiated events c.				
8/60,	death certificate be executed e attending physiclan and d for use as the burial-transit	dical E	Due to (or as a consequence of):				
20	tificate g phys	edic	a				
X R R	eath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	☐ Ectopic pregnancy		23	Bd. Date of delivery Month Day Year
o.	the dea by the at ached fo	Physician/Me	1 Yes 2 No 9 Unknown Unknown 1 Yes 2 No 9 Unknown Unknown Unknown 1 Yes 2 No 9 Unknown Unknown	Other (specify)			World Day Tear
S,	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in P	Part I. 23e		e contribute to the cause of death?
Ö	requir	eted	1. Type 2 de cours mettes	~		1 Yes 2	
Records,	ilcian: The law requires that the decertificate has been signed by the rector, page 2 should be detached	Completed	a. Chesty			autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Vital	ertifica ctor, p	Be C	25. Was case referred to medical examiner?		Place of Death (Check		10103 2010
0	Physic this or	မ	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		Nursing Home 5	•	Other (Specify)
00	ding I h. After funer	tion	27. Manner of Death 1 Matural 5 Pending (Month, Day, Year) 2 Accident investigation 28a. Date of Injury (Month, Day, Year)	of 28c. Injury at Work? M 1 □ Yes 2		scribe how injury	occurred
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		28f. Loca	ation (Street and or Town, State)	Number or Rural Route Number,
_	ospital hours a ineral I		29a. Certifier 1				
	the Ho hin 24 the Fi	Medical	one) and manner stated.	29c. License numt			signed (Month, Day, Year)
	Verit		29b. Signature and title of certifier	DOING	453	290. Date	11109
	3001		30. Name and address of person who completed cause of deat (lite 23a) (type	Print)	Phony A	200	MOSIUOL.
1	Sta		31. Date filed (Month, Day, Year) See 11 2009 32 Registrar's Signature	n Ked	The The		I VIJOLIA
	Registi	ar	LED I I COUR CERON D. HO	-			

09-0133	3		
Detrioia	1	lobnoon	

	- For State Cer	artment of Health and Menta rtificate of Death	Reg. No.	2009 0623
sician/	egistrar 1. Decedent's Name (First, Middle,Last)		2 Date of Death	3. Time of Death
aminer	Patricia Jean Johnson		Month Day February 14, 200	2207 hrs
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of I Bowie		County of Death ince George's
	Route 301 Southbound at Excalibur 5 Social Security Number 6 Sex 7 Age (In yrs. In			D/YYYY) 9. Birthplace (State or
eral ctor	210-44-0627 1 M 2XF	Months Days Hours	Min. Dec. 23, 1	Foreign
_	Usual Residence of Decedent 10a, State 10b, County 10c, City,	, Town or Location		10d. Inside City Limits
28a-f show any d at once. ector	Toa. State	ng George		1 Yes 2 No
호텔 등	10e. Street and Number 8446 Dahlgren Road	10f. Zip Code 22485		en of What Country?
s 23a c se notif	11. Marital Status 12. Was Decedent Ever in U	J.S. 13. Was Decedent of Hispanic Origin	n? (Specify Yes or No- 1	Race - American Indian, Black, White, etc.
r item nust b	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, F		
	Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		Specify: White nd of Business/Industry
	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give ki during most of working life. DO NOT u	ise retired)	
ical	Elementary/Secondary (0-12) College (1-4 or 5+)	Technical Analys		vernment/Militar
e Met	17. Father's Name (First, Middle, Last)	18.Mother's	Name (First, Middle, Maiden S	Surname)
ent, the Be C	Roger Williams		Hall	
Important: If item 27 is marked other than injury or other tranmatic event, the Medical To Be Comple	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Numb	per or Rural Route Number, Cit	y or Town, State, Zip Code)
n 27 it	David Johnson	PSC 122; Box 26		ocation - City or Town, State
or tra	200 Montage 16 - 00-1-	. Place of Disposition (Name of cemetery, crematory or other place)		•
r oth	4 Donation 5 Other Specify: Su	nnyside Cemetery		nkhannock, PA.
port:	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	Marzullo Fu	neral Chapel, P. A
	michael V. marziello	16009Harford R	rdiac or respiratory arrest sho	re, Maryland21214
cian lical	23a. Part I. Enter the disease, of complications that caused the death failure. List only one cause on each line.	ы. Do not enter the mode of dying, such as са		Between Onset and Death
iner	Immediate Cause (Final disease or condition resulting in death) a Multiple Injuries Due to (or as a consequence	of):		
	h	p		
ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	of):		
Insit Examine	cause. Enter Underlying Cause (Disease or righty) that initiated Due to (or as a consequence	of):		
rand transit	events resulting in death) Last Due to (or as a consequence d.	, 		
a tra	UNPENDED AMENDED			A Second Co.
	IF FEMALE: 23c. If yes, outcome of pre			d. Date of delivery
by the attending phached for use as the Physician/W	23b. Was decedent pregnant in the	2 Fetal death 3 Ectopic	pregnancy	Month Day Year
or use	4 Pregnant at time of to 1 Yes 2 No 9 ✓ Unknown 9 Unknown	death 5 Other (Specify)	fi.	
by the ched t	Part II. Other significant conditions contributing to death but not	t resulting in the underlying cause given in Pa		use contribute to the cause of death?
gned b			1 Yes 2	No 3 Probably 4 Unknown
5 - S			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
te lad			autopsy	death?
has been signed by the attending phy e 2 should be detached for use as the npleted by Physician/M			performed?	
page 2		26 Place of Decit	1 V Yes 2 N	
rector, page 2 Be Com	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	26.Place of Death	1 V Yes 2 N	
r this certificate ha ral director, page 2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	Other	1 ✓ Yes 2 N (Check only one) Nursing Home 5 Reside ? 28d. Describe how inj	lo 1 ✓ Yes 2 No ence 6 ✓ Other: Scene ury occurred
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** EENE OLITA 3 UM 0 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City. Town, or Location of Death Examiner Mandrin Hospice House Anne Arundel Harwood If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year Months Days Hours Min. 176-34-8973 1 □ M 2 Ø F 65 Sept. 1943 Pennsylvania **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland I Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at Maryland Anne Arundel Arnold 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 512 Bay Green Drive 21012 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2000No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔼 No Yes Give Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygie
Important: If item 27 is marked other tt
any Injury or other traumatic event, Ins. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martin G. Lane Ruth Thompson မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Raymond E. Keeney, Sr./spouse 512 Bay Green Drive Arnold, Maryland 21012 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Paxtang Mem. Gardens: 2/10/2009 Harrisburg, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Lice 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final year **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ine Hospital or Attending Physicial: The law requires that the death certificate be executed Exami sician and burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 🗌 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>۾</u> 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page certificate 1 ☐ Yes 2 1 ☐ Yes 2 🗆 No Division of Vital director, CB Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence USE 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 6 Other (Specify) After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: # 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and magner stated. within 2. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D 21438 February 09, 2009 ENSE Hattway ANNA POUS MA 2144

3,00

Registrar

31. Date filed (Month, Day, Year) State

Name and address of per

IM Registrar's Signature 32.

ho completed cause of death (Item 23a) (Type

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			For Amend Item 31 State Registrar WCHD/SH 2/18	State of Ma	ryland / Dep	artment of H	lealth and M <i>Death</i>		ene 009	06233
			Decedent's Name (First, Middle, Last)	0, 10,				2. Date of Death	1	3. Time of Death
	Physicia	_	HELEN VIRGINIA	KUHN				FEBRUAR!	Y 14 2009	
	/Medic Examin	33 7	4a. Facility Name (If not institution, give str			4b. City, Town, o	r Location of Death		4c. County of Dea	ath
J.			HOLLY PLACE ASSIST	ED LIVINO	3	H.A	AGERSTOWN		WASI	HINGTON
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) C	rthplace (State or Foreign
и	Director		215-18-1157	4 2 🛛 F	85 Yrs.			FEB. 13	, 1924	MARYLAND
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	shov	7		037			TED CITICAL TAIL			1 X Yes 2 □ No
	the M	Director	MARYLAND WASHINGT	OIN		10f. Zip Code	GERSTOWN_	10	ng. Citizen of What C	country?
	a or			ampiatam			217/.0			
	eath ns 23 musi	Funeral	268 SOUTH POTOMAC 1	. Was Decedent E	ver in U.S. 13.		21740 Iispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-	14. Race - Am	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notifled at	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 N				Rican, etc.)	Black, Wh	ite, etc.
ဗ္ဗ		þ	3 Nidowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify:	WHITE
21215-0036	72 ho	Completed	15. Decedent's Educa (Specify only highest grade of	tion		edent's Usual Occup	oation during most of worki		16b. Kind of Busines	s/Industry
3	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show if Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notifled at	ם	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retire	d) _			
21		ខ្ល	8			HOMEMAKI		(5:	OWN HOL	<u>Æ</u>
Maryland	be fill d oth even	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		,	
₹	2 should be and Mental is marked or anmarked or	은	EARL SYLVESTER HOLM		1 401 14 11		MARJORIE			7-0-4-1
Jar	l 2 sh n and rism raum		19a. Informant's Name/Relationship (Type	e. Print)	1	•			. City or Town, State, $ ext{RSTOWN}$, $ ext{M}$	
	l and lealth		GUY T. KUHN/SON 20a. Method of Disposition	·	20b. Place of Disp				20c. Location - City of	
Baltimore,	Pages nent of h int: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Top	moval from State	cemetery, cre	ematory or other pla	ce)			
計	+ 문원은		4 ☐ Doration 5 ☐ Other (Specify)			MANOR CEM			SHARPSBURG FER FUNERA	G, MARYLAND
Bal	Deparenti Impo any Ir		21. Signa die di Pure al Bavico lice is	Paul I	M l'oon				onsboro, M	
			23a. Part L Enter the disease, Complica	ations that caused						Approximate
		ļ	shock, or heart failure. List only one Immediate Cause (Final	cause on each lin	ie.	6.1 3			1 5	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Chr	consequence of):	strue	une a	neway	disease	lyeans
	Examiner			Due to (of a	Line V	2001				7 may
		ē	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	Due to (or as-	a consequence of):	402)		V		1 11 641/18
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.		U					
ó	exec in an rial-tr	Exa	resulting in death) Last	Due to (or as	a consequence of):					
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d.							
9	rtifica ng ph as th	Med	IF FEMALE:							
Box	leath certific attending p	an/l	23b. Was decedent pregnant 23	c. If yes, outcome 1□Live birth		□Ectopic pregnanc	ey		23d. Date of d Month	elivery Day Year
	ed fo	sici	in the past 12 months? 1 🗆 Yes 2 🗖 No	4□Pregnant at 9□Unknown	time of death 5	Other (specify) _		·	World	Day Tour
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	res tha signed be det	þ	Part II. Other significant conditions cont	ributing to death b	at not resulting in the	underlying cause gr	ven in Fait i.	1 [7] Ye	h. A	Probably 4 Unknown
oro	w require been si should b	Completed								
Sec	ne law has b ye 2 st	nple						24a. Was a autops	sy prior t	autopsy findings available completion of cause of
or Vital Records,		S						perform	med? death 2. I ☐ Ye	es 2 No
Vit.	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	_	lou	26. Place of Deat			Assisted
0	this all dili	2	1 ☐ Yes 254 No Ho	1 ☐ Inpatie		SIK SU DOA	4 LI Nursing Ho		ence 6 M Other (Sp ow injury occurred	pecify) Living
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isi	Attending r death. ector: After by the fune	licat	3 Suicide 6 Could not be	28e. Place of inj	ury - At home, farm, s			28f. Location (Si	reet and Number or	Rural Route Number,
Division	after after Direct	Certification:	4 Homicide	building, et	c. (Specify)			City or Town	n, State)	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer				of my knowledge, de					
	n 24 h	Medical	(Check only 2 Medical Examin one)	er: On the basis o and manner st		investigation, in my	opinion, death occur	rred at the time, o	late and place, and d	ue to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier			_	se number	2	9d. Date signed (Mo	
			1 Manjal	g mo	V	()	28365		2-17-	04
1			30. Name and address of person who cor						_	_
75	H-3		Manzar Shafi,			l Street,	Hagerstow	n, Maryl	and 2174	0
	St Regist	ate	FEB 1.8 FEB 1.2 200	32. Registr	ar's Signature					
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)1369 ter Frank Klaback	O-witionto	Of Health and Mental 1199	iene 2009 0623
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	2	Date of Death Month Day Year February 16, 2009 3. Time of Death 1050 hrs
dical Examiner	Walter Frank Klabacha, Jr. 4a. Facility Name (if not institution, give street and number) 1190 Clopper Road	4b. City, Town, or Location of Death Gaithersburg	4c. County of Death Montgomery
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1	y) If Under 1 Year If Under 24Hrs. Months Days Hours Min. Yrs.	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign IPTTWois
w any	Usual Residence of Decedent 10a. State		10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country?
the Maryland a or 28a-f sh lifted at onc	10e. Street and Number 3408 Fredale Street	20906 3. Was Decedent of Hispanic Origin? (Spe	United States ### Identify Yes or No- 14. Race - American Indian, Black, 14. Race - American Indian, 14. Race - Amer
er death with , or items 23. r must be no Funeral	11. Marital Status 1 Never Married 2 XMarried Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto F Yes 2 No specify:	White, etc. Specify: White
5-0036 ed within 72 hours afte tygiene. other than "natural" he Medical Examine Completed by	15 Decedent's Education (Specify only highest grade completed) 16a. De	cedent's Usual Occupation (Give kind of w ring most of working life. DO NOT use retire penter	Construction
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at once Injury or other traumatic event, the Completed by Funeral Director	Walter Frank Klabacha, Sr.	Lilian C	(First, Middle, Maiden Surname) endreco tural Route Number, City or Town, State, Zip Code)
MD 21 and 2 should be saith and Mer em 27 is man raumatic ev	19a. Informant's Name/Relationship (Type, Print) Lea Klabacha -wife 20a Method of Disposition 20b. Place of	08 Fredale Street S	ilver Spring, Maryland 20906 Date 20c. Location - City or Town, State
altimore, MD mit Pages I and 2 she epartment of Health and portant: If item 27 is jury or other traumat	1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	olitan Crematory 2/ Donald V. Borgward 4400 Powder Mill R	18/2009 Alexandria, Virginia
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not	enter the mode of dying, such as cardiac of	t Funeral Home, PA Marvland2070: Marvland2070: Marvland2070: Approximate Interval Between Onset and Death
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ed nsit	if any, leading to immediate cause. Enter this original Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiconnective filled in by the funeral director, page 2 should be detached for use as the burial - transiconnective filled in by the funeral director, page 2 should be detached for use as the burial - transiconnective filled in by the funeral director, page 2 should be detached for use as the burial - transiconnective filled in by the funeral director, page 2 should be detached for use as the burial - transiconnective filled in by the funeral director.	XUNPENDED X AMENDED #1, as not X AMENDED #1, as not IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting		Name Day Vear
O. Box hat the death ced by the atterded for us	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1
Records, P The law requires the ficate has been signs, page 2 should be d	De de de constant la madical		24a. Was an autopsy findings availab prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Rec		26.Place of Death (Chec	
of Vital Rec Ing Physician: The I After this certificate I	examiner? 1 Ves 2 No 1 No 1 No yes 2 No 28a. Date of Injury 28b.	DOA Other Nur Time of Injury 28c. Injury at Work?	sing Home 5 Residence 6 Other: Scene 28d. Describe how injury occurred
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certi completely filled in by the funeral director	Suicide 6 Could not be determined (Specify)	farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, Cor Town, State)
te Hospita n 24 hours ne Funeral	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, a investigation, in my opinion, death occurre	
To the within To the comp.	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) February 17, 2009
	30. Name and address of person who completed cause of death (Item 23a Pamela E. Southall, MD Assistant Medical Examin	er 111 Penn Street, Baltimore	e, MD 21201
St Regist	trar 31. Date filed (Month, Day Year) 2009 32. Registrar's Signature from the filed (Month, Day Year) 2009 Mensure from the filed (Month) 2009 Mensure from the fi	parle	

			1 _ State		epartment of Health and Certificate of Death		2000 06225
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	LIC	(+	02	Day Year 203 ÔM
	Examir Funeral Director	er	4a. Facility Name (If not institution, give street and number) 931 Edgewood Rd. Apt. 201 5. Social Security Number 358-10-6848 6. Sex 1 □ M 2 □ F	e (In yrs. last birth	4b. City, Town, or Location of Deat Annapolis If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the "notical Event, the Traumatic event, the Model.	Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Anne Arunde1 10e. Street and Number 931 Edgewood Rd. Apt. 201	10c. City, Town	10f. Zip Code	10g.	10d. Inside City Limits 1 □ Yes ⅔️ No Citizen of What Country? USA
21215-0036	"natural", or Item	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed)	lo 16a. I	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 □ Yes 2 □ No Specify: Decedent's Usual Occupation Give kind of work done during most of wor life. DO NOT use retired)	16b	14. Race - American Indian, Black, White, etc. Specify: White b. Kind of Business/Industry
Maryland 2121	vuld be filed within Mental Hygiene. arked other than atic event, the Ma	To Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Joseph Scorza	+)	Homemaker 18. Mother's Nar	ne (First, Middle, Maid	Own Home den Surname)
altimore, Mary	ges 1 and 2 shout of Health and M If item 27 is mal or other traumai		19a. Informant's Name/Relationship (Type. Print) Joseph Greene Son-n-law 20a. Method of Disposition 1□ Burial 2☆ Cremation 3□ Removal from State	20b. Place of E	Mailing Address (Street and Number or Ru Forest Beach RD. A Disposition (Name of crematory or other place)	nnapolis,	MD 21403 Location - City or Town, State
■ Baltim	permit. Pa Departmer Important: any Injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Len Burnie, MD eral Home, P.A. Md 21401			
8760,	Physician // / / / / / / / / / / / / / / / / /	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of	Chronie dhedu		Approximate Interval Between Onset and Death ADM BY WELLINE MARKET STATES ApproxImate App
O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. On the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of the pregnant at the pregnant	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ecords, P.	e law requires that has been signed t e 2 should be dete	Completed by Pl	Part II. Other significant conditions contributing to death bu	t not resulting in t	the underlying cause given in Part I.	1 Ves	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available
f Vital R	nysician: The I nis certificate ha director, page	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatien	nt 2 ☐ ER/Outp	Other:	autopsy performed 1 Yes 2 Inth (Check only one)	
Division of Vital Records,	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Certification: To	27. Manner of Death Natural 5 Pending investigation 3 Suicide 4 Homicide Could not be determined Suicide 4 Homicide Could not be determined Suicide Cou	Year) Inju	me of ury M 28c. Injury at Work? M 1 Yes 2 No n, street, factory, office	28d. Describe how in 28f. Location (Street City or Town, St.	and Number or Rural Route Number,
	To the Hospital within 24 hours to the Funeral completely filled	Medical C	(Check only one) 2 Medical Examiner: On the basis of and marrier sta	examination and	death occurred at the time, date and place for investigation, in my opinion, death occu	irred at the time, date	and place, and due to the cause(s)
)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1)	29b. Signature and title of certifier 30. Name and address of person who completed cause of de	Au m	29c. License number D 2 (4 3	8 Fe	Date signed (Month, Day, Year) Way 06, 2009
	Sta		31. Date filed (Month, Day, Year) SER 1 0 2009 32. Registra	7 445	DEFENSE HIGHL	JAY HN	VAPULIS MOZIYUI

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4:55 Рм 2009 Feb. 11 Virgil Jerome Longo 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Villa Rosa Nursing Home Mitchellville 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Or. Country)
Jan. 17,1928 Washington, DC If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours Months 1 X M 2 □ F 81 579-32-9152 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 □ No College Park Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20740 USA 7514 Citadel Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 図Yes 2 □ No
If Yes, Give
Year or Dates: 1946–1947 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🖾 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Private Elementary/Secondary (0-12) College (1-4or 5+) Masonry Masters Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Barbagallo Joseph Longo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7514 Citadel Drive, College Park, MD 20740 Sylvia Longo / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate Of Heaven Cemetery 2/16/2009 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fune Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Weeks Due to (or as a consequence of): Septicemia Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Parkinsons Disease Years Due to (or as a consequence of). IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 🖾 No 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 🖾 Nursing Home 5 🗀 Residence 6 🗀 Other (Specify) 1∐Yes 2∑No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760 signed by the attendin be detached for use

Physician

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygliene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, in Marical Examination once.

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I

Physician/Medical ð Completed 25. Was case referred to medical examiner? Be Certification: To 28a. Date of Injury (Month, Day, Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

To the Hospital within 24 hours a To the Funeral C State

Rakesh Arora, 14300 Gallant Fox Lane, Suite 222, Bowie, MD 20715 31. Date filed (Month, Day, Year) FEB 1 7 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

Registrar

				State of Ma						-		•	e.	
			1 - For State Registrar	01410 01 111	ar y roar ro		rtificate			oman rij	Reg. No	200	9	0623
	Physicia	an	1. Decedent's Name (First, Middle, La							2. Date of De	Da	y Y	ar	3. Time of Death
	/Medic	al	William J. Milli				41 01			Februar				4:20 PM
	Examin	er	4a. Facility Name (If not institution, given Anne Arundel Med		er			nown, or Lo	ocation of Deat	n		County of Anne A		le1
	Funeral					ast birthday)	If Under Months	1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth			ace (State or Foreigr
	Director		211-10-3306	ILAIM 2LIF	83	Yrs.	Months	Days	Tiodis Iviiii.	04/19/	/192	5 F	enns	sylvania
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10	d. Inside City Limits
	a-fsh	ctor	Maryland Anne Ar	ındel	Harw	ood					1 ☐ Yes 2 🛣 N			
	ith the	Directo	10e. Street and Number				10f. Zip				-	tizen of Wha		•
	n 72 hours after death with the Maryland "natural" or items 23a or 28a-f show wilcal Examinations to reithed at	Funeral	392 Lankford Road	12. Was Decedent	Ever in II S	12	207		anic Origin? (9	inecify Ves or N		ed St		
0	r item	Fun	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Forces?	No					pecify Yes or No o Rican, etc.)			Vhite, et	
3-UU3B	ours a	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1943-	45	1 □Yes 2	. ∭ No	Specify:			Specify:	Wh	ite
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ana	e filed al Hygi I other vent,	Be C	17. Father's Name (First, Middle, Last)					8. Mother's Nar	ne (First, Middle	, Maider	Surname)		
y N	2 should be f and Mental is marked o raumatic eve	2	William Joseph M:		r.					ite Fitz				
	nd 2 sh alth and 27 is m ir traum		19a. Informant's Name/Relationship (Alicia O'Brien Ma	,	Fρ			,		urai Route Numb				,
Σ	ges 1 and 2 should be filed within 72 hours after des to the flut mand Mental Hygiene. If idem 27 is marked other than "natural", or items or other traumatic event, the "hydical Experience".		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Nam	ne of	Jau, Hai	Date 1		ocation - Cit		
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Saltimor	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of There's Service Lice	nsee		22	2. Name and	d Address	of Facility G	eorge P.	. Kal	as Fu	nera	1 Home
П	20 E # 8		· Manac			•						lgewat		MD 21037
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	the death.	. Do not ent	er the mode	e of dying,	such as cardia	c or respiratory a	arrest,			Approximate Interval Between Onset and Death
100	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	5,>	ence of):							1	runs
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9	death certificate a attending physical for use as the t	Physician/Medi	IF FEMALE:											
Š į	ath ce attendi for use	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3 [Ectopic pr					23d. Date o Month		y Day Year
j .	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of de	ain 5L	Other (sp	ecity)						
ν̈́,	ss that gned b	by Pi	Part II. Other significant conditions	contributing to death be	ut not resul	Iting in the u	nderlying ca	use given	in Part I.	23e. Did	tobacco	use contribu	te to the	cause of death?
cords	equire een sij ould b	ted t	acute vena	d faile	-e					1 🗆	Yes 2	_ ∆ No 3[Proba	bly 4 ☐ Unknown
	has b	Completed								24a. Was auto	psy	prio	r to com	sy findings available pletion of cause of
ָ ק	n: Th		OF Mos ones referred to madical							1 □ Yes	2 No	dea 1 🗆	Yes 2	No
= :	yslcia s certi directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2 □ E	ER/Outpatier	nt 3 □ DO	Other:		ath <i>(Check only o</i> Iome 5 ☐ Res	•	6 □Other	Specific	
5 i	ng Phy Iter thi neral	n:T	27. Manner of Death ANAtural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry	28b. Time of		Bc. Injury a Work?		28d. Describe			opecity)	
SIOIS .	tendir leath. tor: A the fu	catic	2 Accident investigatio 3 Suicide 6 Could not b	n			М	1 □ Ye	s 2 No					
	after of Direct	Certification: To	4 Homicide determined		iry - At hor c. (Specify,	ne, farm, str	eet, factory,	office		28f. Location (City or To	Street ar wn, State	nd Number o	r Rurai	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the			nysician: To the best										
	the Ho nin 24 the Fu	Medical	one)	miner: On the basis o and manner sta		ion and/or in				arred at the time				
	70 wit	~	29b. Signature and title of certifier	71. /A	ND		29c.	License n	ZYZ		29d. Da	te signed (A	ionth, D	ay, Year)
,	Dodu		30. Name and address of person who			23a) (Tune	Print)	7 200		Nidica	1	, (1	
١,	M. M.		Suzanne Si	Millivan	mi	> Ar	ine A	rui	reel 1	Nidi ca	y (ent	en	
	Sta Registr		31. Date filed (Month, Day Year)	2009 32. Registra	ar's Signati	ure A	mare de	,						

Certificate of Death Name (First, Middle_Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Tate Chesapeake Hospice House Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2ØF 93 173-05-0521 **Director** Sept. 01,1915 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show event, the Medical Examiner must be notified at MD Anne Arundel Severna Park Funeral Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 604 McKinsey Park Drive, Condo # 403 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married ö 1 ☐ Yes 2X No White þ 3 ₩ Widowed 4 □ Divorced than "natural", Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If item 27 is marked other the any Injury or other traumatic event, the gince. Tax Accountant Accounting 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk unk မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Mulderick/ Son Stevensville, MD 21666 7501 Kent Point Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, INC. 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Barranco & Sons, Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. /art1. Effet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. i mediate ause (Final isease / r condition esulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 menths? Year 5 Other (specify) 1 ☐ Yes 2 **N**O 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) # 05 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) Injury 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Pr wo 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

		For State State Registrar	of Maryland / Dep	partment of Health a ertificate of Death	апо мента пу	Reg. No. 2009	06239
Physici	an	1. Decedent's Name (First, Middle, Last)	•	1-	2. Date of De Month	Day Year 2009	3. Time of Death am 5:15 M
/Medic	al	Anne Sa 4a. Facility Name (If not institution, give street and	number) Morr	4b. City, Town, or Location of		4c. County of Dea	th
LXaiiiii		Randolph Hills Nur	sing Home	Wheaton	24 Hrs. 8. Date of Bi	Montg	omery thplace (State or Foreign
Funeral Director		5. Social Security Number 156-03-7002 6. Sex 1 □ M 2 ☑	7. Age (In yrs. last birthda 87 Yrs.	Months Days Hours	Min. 12/0!	o / 1921 Nev	Jersey
rland ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or				10d. Inside City Limits
e Mary Ba-f sh	ctor	MD Montgomery	Wheat			10g. Citizen of What C	1 □Yes 2 No
3a or 2	J Dire	10e. Street and Number 4011 Randolph Road	3	10f. Zip Code 20902		USA	
Defillingtey, Marylattic Z. 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examination usited an any injury or other traumatic event, it a Medical Examination usited an any injury or other traumatic event, it as Medical Examination and approximation and any other traumatic event, it as Medical Examination and approximation and app	by Funeral Director	1 Never Married 2 Married 1 Yes.	Decedent Ever in U.S. I Forces? BS 2X No Give or Dates:	Was Decedent of Hispenic Ori If Yes, specify Cuban, Mexican □Yes 2 No Specify:			
in 72 hour	Completed	15. Decedent's Education (Specify only highest grade complet	ed) (Gir	cedent's Usual Occupation we kind of work done during mos b. DO NOT use retired)	t of working	16b. Kind of Business	·
d withi	Comp	12	e (1-4or 5+) ACC	countant	er's Name (First, Middle	Dept.of	Army
d be file ental Hy ced oth	Be	17. Father's Name (First, Middle, Last) unknown		unk	er's Name (<i>First, Middi</i> l C nown	e, Maiden Surname)	
Mary Ind 2 should alth and Me 27 Is mark r traumati	은	19a. Informant's Name/Relationship (Type. Print) Ronald Morreale/So	on 13	ailing Address (Street and Numb 341 Monroe St	er or Rural Route Num	ington,D.C	2.20011
dillinore, rmit. Pages 1 a partment of He portant: If item y injury or othe		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation			Date /19/2009	20c. Location - City of Arlington	n,Va.
Departit. Departments any injugance.		21. Signature of Fundal Service Licensee	N	音性性 Aty SRY NE 9241 Columbia	MDI FUNE Blvd.Si	RAL SERVIO lver Spri	CE, P.A. ng, Md20910
Physician /Medical			on each line.	enter the mode of dying, such es		arrest,	Approximate Interval Between Onset and Death
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ficate be executed physician and streets the burial-transit	edical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C. Dur					
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40 00 01	Completed	diabetes mellitus	s typeII		24a. Wa aut per 1 🗆 Yes	opsy prior to formed? death?	autopsy findings available o completion of cause of
VITAL HE sician: The la certificate ha irector, page 2	Be C	25. Was case referred to medical examiner?		Other	e of Death (Check only	one)	
Of \ Physical tricks of the serial directions and the serial directions are serial directions.		27. Manner of Death 28a. I	1 ☐ Inpatient 2 ☐ ER/Outpa Date of Injury 28b. Tim	e of 28c. Injury at		sidence 6 Other (Spee how injury occurred	pecify)
Division of VIta vite Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Certification: To	2 Accident investigation 3 Suicide 6 Could not be	Month, Day, Year) Injui Place of Injury - At home, farm, building, etc. (Specify)	M 1 □Yes 2 □	28f. Location	(Street and Number or lown, State)	Rural Route Number,
Hospital 24 hours a Funeral C	Medical Ce	(Check only 2 Medical Examiner: On	o the best of my knowledge, d the basis of examination and/o manner stated.	leath occurred at the time, date a per investigation, in my opinion, de	and place, and due to the ath occurred at the time	he cause(s) and manner e, date and place, and d	as stated. ue to the cause(s)
To the within 2 To the соттре	Mec	29b. Signature and title of certifier	7	29c. License number		29d. Date signed (Mo.	
1		1 Khouse /	towntan	D56691		Feb.10,	2009
		30. Name and address of person who completed Goushia Sultana M		pe, Print) eritage Park	Circle Si	lver Spri	ng,Md 2090
S ⁱ Regis	ate trar	31. Date filed (Month, Day, Year)	32 Registrar's Signature				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Melvin Eugene Miller February 10, 2009 6:20 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 XM 2 □ F March 26, Pennsylvania 90 1918 181-03-2860 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f shov 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number iral", or items 23a or 20902 USA 9808 Forest Grove Drive Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2K Married 2 **N**O Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2 X No <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "natur 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Law **Attorney** 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Dora M. Miller Unknown ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9808 Forest Grove Drive, Silver Spring, MD 20902 Mary Jane Miller/ Wife Health tem 27 i item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 16, permit. Page Department of Important: If any Injury or once. Parklawn Memorial Park Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd., W. Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician Minutes** disease or condition resulting in death) Myocardial Infarction /Medical Due to (or as a consequence of) **Examiner** Right Renal Tumor Ablation 2 vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dius to (or as a nonsequence of): To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Exami and resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 □ No signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Generalized Arteriosclerosis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy 1 ☐ Yes 2 🖾 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2∐No 1 ☐ Inpatient 2 XXER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident Director: d in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined n 24 hours after on Euneral Director 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D15060 February 10, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Peter S. Birk, MD 31. Date filed (Month, Day, Year, 82. Registrar's Signature State FEB 12 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:00 P M 10, 2009 February William Michael McGuigan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 7020 Calvert Drive Elkridge If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Sex 10 M 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Yrs June 28, 1954 Washington, D.C 54 Director 212-66-9534 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experiment part of the contribution 1 □Yes 2√√2 No Director MD Elkridge Howard 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number death with USA 21075 7020 Calvert Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕍 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Assistant upstired ctor Chief 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telecomm. Services Staff Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Mary Rollman William Thomas McGuigan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7020 Calvert Drive Elkridge, MD 21075 Susan McGuigan/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 02/13/09 Odenton, MD Going Home Cremation Service P.O. Box 784 Signature of Funeral Service Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ATEXAL SCLEROSIS **Physician** AMYOTROPHIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t autopsy certificate 1 ☐Yes 2 🛣 No or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending ours after death.
neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 🔲 Homicide determined To the Hospital o within 24 hours af To the Funeral Di 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

10

Nicholas J. Maragakis, M.D. 31. Date filed (Month, Day, 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

600 N. Wolfe Street Meyer 6-119 Balto., MD 21287

29c. License number

20053872

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		,	Ce	rtificate of l	Death	R	eg. No. 2	009	062	42
	Physicia	n	1. Decedent's Name (First, Middle						Date of Deat Month	Day	Year	3. Time of Dea	
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	Examin	er	4a. Facility Name (If not institution Gilchrist Hospi	•	ilber)		Towson Baltimore					e	
.•	Funeral Director			6. Sex 1 M 2 □ F	7. Age (In yrs.	last birthday) Yrs.		If Under 24 Hrs Hours Min		Year) 1948	9. Birthp Coun MD	lace (State or Fo try)	reign
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	r 28a-	rect	MD Howar 10e. Street and Number	u .	\) TOUR DE	10f. Zip Code		1	0g. Citizen of	What Coun	try?	
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	r dear	Funeral Director	11. Marital Status	Armed Fo		.S. 13.	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.		
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N	iled w Hygiei ther tl		17. Father's Name (First, Middle,	ast)		Sec	curity Su		me (First, Middle, I		urity me)		
ana	d be f ental l ked of	To Be	Alfred Nelson M					MaryEl	len Haine	es			
ary	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene of Health and Mental Hygiene them 27 is marked other than "natural", or items 23a or 28a-f show them traumatic event, it. Medical Eventinar must be rediffed at	F	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Numbe									Code)	
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	permit. Pages 1 Department of I Important: If ite any injury or ot once.		4 ☐ Donation 5 ☐ Other (Si		M01		Crematory 2. Name and Addre		2-2009 rry H. Wi	Hanove			na
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I			23a. Part 1. Enter the disease, or shock, or heart failure. List	only one cause on e	ach line.	th. Do not er	ter the mode of dyi	ng, such as cardi	ac or respiratory are	rest,		Approximate Interval Betwee	en
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6876U	ficate be executed physician and s the burial-transit	Medical		d									
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7.	law requires that the de as been signed by the 2 should be detached	by Ph	Part II. Other significant condition	ons contributing to d	eath but not re	sulting in the	underlying cause giv	ven in Part I.				ne cause of deat	
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	Phys r this ral dir	2	1 Yes 2 No 27. Manper of Death	28a. Date	Inpatient 2 [of Injury	28b. Time	MK 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	T LINGSHING	Home 5 ☐ Resid			1 Tope	ce
0	Attending Physician: If death. ector: After this certific by the funeral director, I	atior	1 Natural 5 Pendin 2 Accident investi	9 '	nth, Day, Year)	Injury		rk?]Yes 2 □No					
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	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifyir (Check only 2 Medical	ng Physician: To the Examiner: On the I and mar	e best of my kr basis of examin nner stated.	nowledge, dea nation and/or	th occurred at the t nvestigation, in my	time, date and pla opinion, death oc	curred at the time,	cause(s) and i	manner as s e, and due to	tated. the cause(s)	
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((ot) or		30. Name and address of person	n 12- Bil	nc 67	01 N-	Clules	St. Be	lts. ms	212	0,50		
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1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death State of Maryland / Department of Health and Mental Hygiene Certificate of Death										
1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death						
Goldie Ellen Marquis		February	11 2009	12:19p						
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death							
Holy Cross Hospital	Silver Spring	La para depart	Montgomery	, (Otata - Forci						

Examine

Funeral Director

28a-f show

23a or

"natural", or items

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marked other alth and Mental Hv

3altimore, Maryland 21215-0036

traumatic event, the Medical Examiner roust be notified at Director Funeral þ Completed Be ပ permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun

Physician /Medical Examiner

sician and burial-trans cate has been signed by the attending physician page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral filled in by

Physician /Medica Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Min 1 □ M 2√2 F 11/5/1925 Maryland 456-40-8306 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 1 ☑ Yes 2 ☐ No Maryland Montgomery Wheaton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20902 12023 Judson Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 □Yes 2 □No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 □Yes 2 ¬No Specify: White 3 → Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Walter Reed Hospital Payroll Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George W. Jackson Ellen C. Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20902 12023 Judson Road, Wheaton, MD <u> Glenn Marquis – Son</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 15d Burial 2 ☐ Cremation 3 ☐ Removal from State 2/18/2009 Brentwood, MD Fort Lincoln Cem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd, Brentwood, MD 20722 23a. Part1. Enter by disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 Ho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0064588 D 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD Ashish Tolia, MD 31. Date filed (Month, Day, Year) 32. Registrar's Si State

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 8.9 per hosp g892 6-10-09 vt
State of Maryland / Department of Health and Mental Hygiene
amend 19a per hops. g888 2/27/09 the Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Mata Year 2007 19 208PM January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Agnes If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months NONE 1 M 2 X F Yrs. Director 1-19-09 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? lay shire Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or iter any Injury or other traumatic event, the Medical Examinar ☐Yes 2 No Yes, Give Never Married 2 Married Baltimore, Maryland 21215-0036 1 Ves 2 No Mexican Completed by 3 ☐ Widowed 4 ☐ Divorced Hispanic Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Infant none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P 19a. Informant's Name/Relationship (Type. Print)
Griselda Hurtado / mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21229 Baltimore maruland Avenue 900 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State may 01,2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) New Cothedra Cemetary 22. Name and Address of Facility 5T AGNES
900 5 CATON AVEN
BALTIMORE, MARYLA 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. duend MARYLAND Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Extreme Prematurit **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter of partial Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ ₩6 Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown certificate has been signed by t rector, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Year 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lfimo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

1 - State

			1 - State Registrar			Certi	ficate of i	Death			Reg. No	. 20	119	NA	241
			1. Decedent's Name (First, Midd.	le, Last)					:	2. Date of De	ath D	91/	Ye ar	3. Time o	
	Physicia /Medic		Richard	Κ.			Nel	son]	Month Februa	ry 7	, 200	9	7:2	4AM ^M
	Examin		4a. Facility Name (If not institutio			4	b. City, Town, or		of Death		40	. County			
			4948 Filbert St				Shady		04 11			Anne			
	Funeral Director		5. Social Security Number 220-50-5616	6. Sex 7. Agu	e (In yrs. last birth		f Under 1 Year Months Days	If Under Hours	Min. {	8. Date of Bir (Month, Da 3/12/4	th ay, Year 8)	9. Birth Cou	place (State intry)	or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locati	ion							10d. Inside C	ity Limits
	//aryla	ō		Arundel	Shad									1 □ Yes	2 XX Vo
	the N 28a- notifi	Director	10e. Street and Number	Aldidel	bilad		10f. Zip Code				10g. C	itizen of V	Vhat Cou	intry?	
	3a or	Ö	4948 Filbert S	treet			207	64			US	SA			
	ms 2	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. Was	s Decedent of H	lispanic Or	rigin? (Spec	cify Yes or No)-			ican Indian,	
21215-0036	d 2 should be filed within 72 hours after death with the Maryland it and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it is Mudical Examiner must be notified at	þ	1 ☐ Never Married 2 🔀 Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	No		es, specify Cuba	Specify		ican, etc.)		Specify	k, White,	White	
2-0	72 ho	etec	15. Deceder	nt's Education est grade completed)	16 <i>a</i> .	Deceden	it's Usual Occup	ation	st of working	а	16b. l	Kind of Bu	siness/Ir	ndustry	
21	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		NOT use retired		`			A			
2	lled w Hygie her ti		17. Father's Name (First, Middle,	Last	5	ervi	ce Writ		or's Namo	(First, Middle	Maide	Auto			
anc	ould be fi Mental I arked ot atic ever	Be	Leon	Lasty	Nelso	n			oline		, maraci	ii oumum		okes	
Maryland	should ind Mer marke umatic	으	19a. Informant's Name/Relations	ship (Type Print)			Address (Street				er City	or Town			
<u>S</u>	nd 2 sho Ith and 27 is ma		Shannon Nelson	Spouse			ilbert							,	
ē,	f Hea f Hea item		20a. Method of Disposition	,	20b. Place of	Disposition	on (Name of ory or other plac	201	Da	ate	20c. L	_ocation -	City or T	own, State	
Ê	Page tent o nt: If		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (5				remator		2/13/	09	G1	en Bu	urni	e,MD	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		21. Signature of Euneral Service				ame and Addre		•	D A	1	2 Dia	daal.		401
_	40 = 40 Ct		23a. Part 1. Enter the disease, o	011	About all Dans							2 1(1)	ager.	Approxima	
			shock, or heart failure. List mmediate Cause (Final	t only one cause on each lir	ne.			_			mest,			Interval Be Onset and	tween
	Physician /Medical		disease or condition resulting in death)	a. M.7 4 C C	a consequence o	120	In.	= 1916	271	EN"			-		
	Examiner			Due to (or as	a consequence of	π):									
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	cuted nd ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	` .											
o	e exe ian ar irial-ti		resulting in death) Last	Due to (or as	a consequence o	f):									
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9 ×	certificate be executed ding physician and se as the burial-transit	/Medical	IF FEMALE:	00- W											
O. Bo	death of attended for us	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death		ctopic pregn <i>a</i> nc other (s <i>pecify</i>) _	:y					te of deliventh	very D <i>a</i> y	Ye ar
<u>.</u>	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditi	ons contributing to death be	ut not resulting in	the unde	erlying cause giv	en in Part	I.	23e. Did 1	tobacco	use conti	ribute to	the cause of	death?
Records,	luires n sigr lld be	d by	HIPERTE	NEIGH						1 🗆	Yes 2	2 □ No	3D Pro	obably 4 □	Unknown
ပ္ပ	w requir s been s should	Jete	HI PARCE	10 hmit						24a. Was		24b. \	Were aut	opsy findings	available
	sIclan: The law certificate has b irector, page 2 s	Completed								auto perfo 1 □ Yes	ormed?		death?	ompletion of 2 □ No	cause of
Vita	lan: '	Be C	25. Was case referred to medica	d				26. Plac	e of Death	(Check only			1 1 1 0 3	2 🗆 110	
-	₹ iši	1	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Out	patient	3 □ DOA Oth	er: 4□N	lursing Hom	ne 5 Resi	idence	6 □Oth	er <i>(Sp</i> ec	ify)	
0 0	nding Phys th. : After this e funeral dir	tion:	27. Manner of Death 1 Natural 5 Pendir 2 Accident invest	28a. Date of Inju (Month, Da igation	ry 28b. Ti y, Year) In	ime of ijury	28c. Injur Worl M 1 🗆	y <i>a</i> t k? Yes 2□		8d. Describe	how inju	ury occurr	ed		
Division of	I or Atter after des Director	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	not be nined 28e. Place of Injubuilding, etc.	ury - At home, fari c. (Specify)	m, street	, factory, office		28	8f. Location (City or To			er or Rui	ral Route Nui	mber,
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the best Examiner: On the basis o and manner sta	f examination and	, death o	ccurred at the ti stigation, in my o	me, d <i>a</i> te <i>a</i> opinion, de	and place, a ath occurre	and due to the	e cause(, date ar	(s) and mand place, a	anner as and due	stated. to the cause(s)
	To the within Fo the Somple	Me	29b. Signature and title of certific				29c. Licens	e number			29d. D	ate signe	d (Month	, Day, Year)	
			Marke	111	1: 120	,	11-1	61	209	0	2	-	10-	09	
	^		30. Name and address of person	who completed cause of d	eath (Item 23a) (*	Type, Pri	nt)	6 6		-		-			
	20		STANICKY W/15	WILLEAN	Mrn-	3	2 Cop	1-01	10 /1	WAIT!	1061	row.	1) 1	40 21	0639
	Sta		31. Date filed (Month, Day, Year,	1 2009 32. Registr	eath (Item 23a) (1									
	Registr	ar	1 40 1	I LUUU Alores	vas p.	140	all con								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Dep	artment of Health and I		ne No D D Q	0621.6		
Ì	Physici	_	1. Decedent's Name (First, Middle, Last) PEARL NEWNAM		2. Date of Death	Day Year	3. Time of Death 9 2:00 p ^M		
Ì	/Medic Examir		4a. Facility Name (If not institution, give street and number) Chester River Hospital	4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent)		
	Funeral Director		5. Social Security Number 216-40-3592 6. Sex 1 M 2 M F 7. Age (In yrs. last birthday 86 Yrs.) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month Day Ye	ear) Cou	place (State or Foreig intry) ryland		
e, Maryland 21215-0030	nould be filed within d Mental Hygiene. narked other than "natic event, the Me		10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10c. Street and Number 10f. Zip Code 10g. Citizen of What County 10g. Citizen of Wh						
Baltimore	permit. Pages 1 Department of F Important: if ite any injury or ot		4 Donation 5 Other (Specify) 21. Signal Tune Sewi 2 Danse M00510	Cemetery 2/2 22. Name and Address of Facility Galena Funeral 118 West Cross	25/09 G Home of St. Gale	Salena, M Stephen	MD.		
8/00,	death certificate be executed Wedical Examine e attending physician and dor use as the burial-transit	dical Examiner	23a Rank Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cau et (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2a. Cardio-vasc Due to (or as a consequence of): Diabetes Me Diabetes Me Diabetes Me Due to (or as a consequence of): Hypertensio: Due to (or as a consequence of):	ular disease llitis			Inferval Between Onset and Death 20 years 20 years 15 years		
O. Box 62	death certific e attending p id for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	very Day Year		
Vital Records, P.	requires that been signed should be de	Completed by Phy	Part II. Other significant conditions contributing to death but not resulting in the Dementia	underlying cause given in Part I.	23e. Did tobac 1 ☐ Yes 24a. Was an autopsy	24b. Were au	the cause of death? bably 4 Unknown topsy findings available completion of cause of		
Division or Vital Re	ing Physiclan: After this certifica	Certification: To Be Com	25. Was case referred to medical examiner? 1	ent 3 DOA Other: 4 Nursing F of 28c. Injury at Work? M 1 Yes 2 No	performer 1 □ Yes 2 ₺ atth (Check only one) Home 5 □ Residence 28d. Describe how	d? death? No 1 Yes De 6 Other (Specinjury occurred	2 □ No		
)	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the f	Medical (29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowledge, deadless of examination and/or and manner stated. 29b. Signature and title of certifier	29c. License number	urred at the time, date		n, Day, Year)		
	St Regist	ate trar	30. Name and address of person who completed cause of death (Item 23a) (Type Elizabeth P. Sipala, C. 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature	R.N.P. 119 C N	. Main S	t. Galen	21635 a, MD		

DHMH 17 Rev 1/2001

		For State Registrar	State of Marylan	d / Depa	artment o	of Healtl	n and M	•	giene	200	06247
		Decedent's Name (First, Middle, Last)						2. Date of De	ath		3. Time of Death
Physici	_	margaret	Nichols					Month	17	Year O 9	12:30AN
/Medic Examir		4a Facility Name (If not institution, give s	treet and number)		4b. City, To	wn, or Locati	on of Death		4c.	County of Dea	
		Citizen's Care +	Rehab Ctr.		Fred	deric	k		F	rede	
Funeral		Social Security Number 6. Sex	X-		Months D	Year If Und	der 24 Hrs.	8. Date of Bir (Month, Da	rth ay, Year)	9. Bir <i>C</i> c	thplace (State or Foreig ountry)
Director		207-32-1977	M 7NF 83	Yrs.				Jan. 1	13, 1	926 Sou	ıth Carolin
and		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or L	ocation						10d. Inside City Limits
Marylan f show	ō	Maryland Washing	ton		Hagers	town					1 □ Yes 2 No
within 72 hours after death with the Maryland ene. than "natural", or flems 23a or 28a-f show he Medical Exambar must be motified a	Funeral Director	10e. Street and Number			10f. Zip Co				10g. Cit	izen of What Co	ountry?
3a or	ID	18614 Preston Roa	đ			21742				U.S.A.	
death	Jera	11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Deceden If Yes, specify	nt of Hispanic	Origin? (Spe	ecify Yes or No	0-	14. Race - Ame	
after or Ite	Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2√2			nicali, etc.)		Black, Whit	te, etc.
ral',	l by	3√ Widowed 4 Divorced	Year or Dates:		10.00	3140 3000	y.			Specify: M	Mite
72 h	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual C kind of work	done during r	nost of work	ing	16b. K	ind of Business	/Industry
id within 72 hours af giene. er than "natural", or i he Medical Exam	Пр	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use i	,				77 a m	
filed v Hygie other t		12 17. Father's Name (First, Middle, Last)		HC	omemake		other's Name	e (First, Middle	. Maiden	HOMe	2
d 2 should be file th and Mental Hy ?7 is marked oth traumatic event	Be	Andrea Jackso	n Gaskin					a Lou M		ŕ	
2 should be filed with and Mental Hygiene. Is marked other that aumatic event, the	2	19a. Informant's Name/Relationship (Ty		19b. Mail	ing Address (S	Street and Nu				or Town, State,	Zip Code)
d 2 s th an trau		John B. Nichols	(Son)	1						and 2174	
ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygiene. If flem 27 is marked other than "natural", or flems 23a or 28a-f show or other traumatic event, the Medical Examinal mount be notified at		20a. Method of Disposition	20b. F	lace of Disp	osition (Name	of		Date	_	ocation · City or	
Pages nent of int: If It ury or o		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	emoval from State		matory or other cg Crem		1	ruary 2009	Smi	thsburg	, Maryland
		21. Signature of Funeral Service License			2. Name and A					- Tuneral	
permit. Pages 1 a Department of Her Important: If Item any injury or othe	1	Halley 6	DAVIS MOI	414	12525 B	radbur					land 21783
Physician /Medical Examiner	ler	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a conseq	uence of):	andio	Vaseu	ulan .	Clisers	e_		Interval Between Onset and Death
ificate be executed g physician and as the burial-transit	icai Examiner	resulting in death) Last Due to (or as a consequence of):									
that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	□Ectopic preg □ Other (spec					23d. Date of de Month	livery Day Year
requires that the		Part II. Other significant conditions con	ntributing to death but not res	ulting in the	underlying cau	se given in P	art I.			La	o the cause of death?
w require been sig	ed	demented						1 🗆	Yes 2	No 3□P	robably 4 Unknow
The law ate has b	Completed by							24a. Was auto perf 1 \(\text{Yes}		prior to death?	utopsy findings available completion of cause of s 2 No
Physician: The this certificate	Be	25. Was case referred to medical examiner?	lospital:			26. P		h (Check only			- 5
Phys this al di	- To	1 ☐ Yes 2 🕱 No 27. Manner of Death	1 Inpatient 2 28a. Date of Injury	ER/Outpatie		. Injury at	Nursing Ho	me 5 ☐ Res 28d. Describe		6 ☐Other (Spe rv occurred	ecity)
Jing After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	M	Work? 1 ☐ Yes	2 🗆 No			,	
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, s fy)	treet, factory, o	office		28f. Location City or To			ural Route Number,
ne Hospital n 24 hours a he Funeral Dietely filled	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.								
To the within to the comp	Ž	29b. Signature and title of certifier	20		29c. L	License numb	oer		29d. Da	ite signed (Mon	th, Day, Year)
		* XMYX. K	afmon	IM	01)_/3	711		2	1/9/	09
		30. Name and address of person who co				17 1	1 - 1	MD 017	01		
		Robert L. Kaufman					rick,	MD 21/	UI		
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registra/s Signa 7 2009	ature	bar	Kal					

DHMH 17 Rev 1/2001

ORIGINAL

DK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 0 0 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** ARKE 06304 Ry JWE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Jan. 13, 1922 of Columbia 5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 200 F 87 577-24-8457 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avent, the Medical Examment must be notified at MD Anne Arundel Arnold 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 510 Bay Hills Drive 21012 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Home Homemaker 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental High Important: If ten 2.7 is marked any injury or other? 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ada Argenbright Benjamin Rowe ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William H. Parker/ Husband 510 Bay Hills Drive Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Feb. 07, Metro Crematory, INC. Baltimore, MD 2009 21. Signature of Funeral Service Vicens Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease r condition resulting in death) ouch eon **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed use as the burial-transit Due to (or as a consequence of): physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No jo 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ arelie an 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page 1 ☐ Yes 2 ☐ No 1 Yes 21-No certificate of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Hospital: Impatient Other: 2.2 No P 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) his funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; After Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by after 4 - Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 24 To the F 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 21438 Ebruary 06,2009

State

31. Date filed (Month, Day, Registrar

Year)

32. Registrar's Signature

441

pleted cause of death (Item 23a) (A

HNNAPOUS MA 21401

Taltwm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Of Maryland / L State Registrar	Certificate of		-	Reg. No.2	009	06249
	Physicia	n	1. Decedent's Name (First, Middle, Last)			2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		Darryl Anthony Quick			02	07	2009	9:35A M
	Examin	er	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital	Rockvil	or Location of Death	1	1	ounty of Death	37
سر	Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birt	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		9. Birthp	lace (State or Foreign
	Director		370-04-3413	Yrs. Months Days	Hours Min.	8. Date of Bir (Month, Da 5/13/1	960	Couin	DC
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				11	0d. Inside City Limits
	Mary Ind	to	DC N/A Wash	ington					1X Yes 2 □ No
	h the	Director	10e. Street and Number	10f. Zip Code			10g. Citizer	of What Coun	try?
	23a c	ral	814 Farragut Street, NW	2001				ed Stat	
36	should be filed within 72 hours after death with the Maryland nd Mental Hyglene marked other than "natural", or items 23a or 28a-f show matic event, the Medical Extrainer matt be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No		pecify Yes or No o Rican, etc.)	T T	14. Race - American Indian, Black, White, etc. Specify: African	
21215-0036	thour		15. Decedent's Education 16a.	Decedent's Usual Occ			16b. Kind	of Business/Inc	ican
دا 2	filed within 72 Hygiene. other than "na ent, I'm Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work don life. DO NOT use retir	e during most of wor red)	king			
7	ed wit ygien ier th: t, the	Con	1 E	arber	T	(F) A A C II.	Priv		
Maryland	be fill ntal H ed oth	Be	17. Father's Name (First, Middle, Last) Robert T. Quick, Sr.		18. Mother's Nan	s Chavis		manie)	
Ž	2 should n and Mer is marke raumatic	ဥ		Mailing Address (Street				own, State, Zip	Code)
	s 1 and 2 should of Health and Mer item 27 is marke other traumatic			42 M Stree				20019	
J.	ss 1 a of Hea item		20a. Method of Disposition 20b. Place of cemeter	Disposition (Name of y, crematory or other pi	lace)	Date	20c. Loca	tion - City or To	wn, State
Ĕ	Pages ment of ant: If its ury or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rock C	reek Cemet				ington,	
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee		ress of Facility Margia Avent				
			23a. Part 1. Enter the disease, or complications that caused the death. Do n	1				geon, I	Approximate Interval Between
=	Physician	8 2	shock, or heart failure. List only one cause on each line.						Onset and Death
	/Medical		disease or condition resulting in death) The disease or condition resulting in death) Due to (or as a consequence of the disease or condition)						
	Examiner		Massive Intra		norrhage,	Non Tra	umati	С	
	led sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	of):					
)	execut and al-tran	Examiner	that initiated events resulting in death) Last C	of):					
68760,	tificate be executed by physician and as the burial-transit	edical I	d						
			IF FEMALE:		_				
P.O. Box	Physician: The law requires that the death cert this certificate has been signed by the attending all director, page 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregna 5 ☐ Other (specify)			230	d. Date of delive Month	ery Day Year
	res that signed b be deta	by PI	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause of	given in Part I.	23e. Did	tobacco use	contribute to the	ne cause of death?
ğ	w require been signature					1 🗆	Yes 2X	No 3□ Prob	pably 4 Unknown
Division of Vital Records,	Physician: The law r this certificate has be al director, page 2 sh	Completed				24a. Was auto perfe 1 ∐Yes	opsy ormed?	24b. Were auto prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of 2 No
/ita	iclan: Sertific ector,	Be (25. Was case referred to medical examiner?	- *	26. Place of Dea				
ō	Physical direction	P.	1 Tes 2 Invo	tpatient 3 DOA Time of 28c. In	other: 4 Nursing F	lome 5 ☐ Res 28d. Describe			(y)
o	Jing Taftel fune	tion	1 Natural 5 Pending (Month, Day, Year) I 2 Accident investigation	njury W	ork? □Yes 2□No	200, 2000, 20	now injury o		
Divisi	al or Attendates after death	Certification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	е	28f. Location City or To	(Street and I wn, State)	Number or Rura	al Route Number,
	To the Hospital or Att. • within 24 hours after de To the Funeral Direct completely filled in by t	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination are and manner stated.	e, death occurred at the nd/or investigation, in m	time, date and plac y opinion, death occ	e, and due to the urred at the time	e cause(s) a , date and p	nd manner as s lace, and due to	stated. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	29c. Lice	nse number		29d. Date :	signed (Month,	Day, Year)
	4		Outy day M.D.	D00	065505		Februa	ary 7,	2009
	1		30. Name and address of person who completed cause of death (Item 23a) Qiufang Cheng, M.D., 9901 Medica1		, Rockvil	le, MD			
	Sta		31. Date filed (Month, Day, Year) 32. Aegistrar's Signature		-				
	Registi	teli	FEB 12 2009 Denne B.	garan					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ROSS Day STANLEY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Ginger Cove Annapolis 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 8/18/1918 9. Birthplace (State or Foreign Country) Mississippi 5. Social Security Number 7. Age (In yrs. last birthday) 90 500-14-5302 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Maryland | Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 8305 River Crescent Drive 21401 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. vvas Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No WWII IfYes, Give Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No White Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 5+ College (1-4or 5+) Elementary/Secondary (0-12) Investment Banker Municipal Bonds 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Simon Peter Ross Evans Mande 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Cook Ross/Wife 8305 River Crescent Drive Annapolis, MD. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State Kalas Crematory 2/9/2009 Edgewater, Maryland 4 ☐ Donation Jo ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature Funeral Service Licensee 2973 Solomons Island Rd. Edgewater, MD. aldx Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events. Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 6 Other (Specify) COVE Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 4 27 Manner of Death 28b. Time of 70 L12 28c. Injury at Work? 1 Natural 2 □ Accident 5 ☐ Pending investigation 1 □Yes 2 □No

P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a fer death.

To the Funeral Director After this certificate has been signed by the attending newsician and attending physician and for use as the burial-transit signed by the at d be detached for Division of Vital Records, cate has b page 2 st After thi funeral nours a er death.
neral Director /

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ira Medical Examinating Italian 21 once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

State

31. Date filed (Mont Registrar

29b. Signature and title of certifier

Name and address of

6 ☐ Could not be

determined

competed cause of death (Item 23a) (Type, Print 32 Registrar's Signatur

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d_Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and memor stated.

29c. License number

		• •	or Print in Bl				-		-		
		1 - State Registrar	ate of Maryland		epartment of F Certificate of I		Mental Hy	giene Reg. No			
Physicia /Medic		1. Decedent's Name (First, Middle, Last)	Remse	28	J		2. Date of De Month		3. Time of Death		
Examin Funeral Director		4a. Facility Name (If not institution, give street 5. Social Security Number 6. Sex 219-48-6751 6. Sex	7. Age (In yrs. las	st birtho	Months Days	Location of Dea	8. Date of Bi	rth ay, Year,			
f show	or	Usual Residence of Decedent 10a. State 10b. County	10c. City,					1 754	10d. Inside City Limits 1 □ Yes 2 □ No		
with the Magarian or 28ari	Funeral Director	Maryland Anne Arunde 10e. Street and Number 3938 West Shore Driv		vate	10f. Zip Code 2103	7			itizen of What Country?		
ire, INIAL yial to Z I Z I D-UUJO s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Its Fudical Evenior miss the notified at	by	Ar 1 Never Married 2 Married 1 €	as Decedent Ever in U.S. med Forces? ∏Yes 2 ∰No /es, Give ar or Dates:		13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No	ispanic Origin? (In, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.))-	14. Race - American Indian, Black, White, etc. Specify: White		
Z I Z I 3-0	Completed	15. Decedent's Education (Specify only highest grade composition of the Elementary/Secondary (0-12)	oleted) ollege (1-4or 5+)	(C	ecedent's Usual Occup Give kind of work done of fe. DO NOT use retired hanic's He	during most of wo l)	orking		Ounty Government		
yidriu	To Be C	17. Father's Name (First, Middle, Last) Peter Remsen, Jr.				Beatr	me <i>(First, Middle</i> ice Elai	, <i>Maider</i> ne K	ern		
e, Mar 1 and 2 sh Health and em 27 is n ther traun		19a. Informant's Name/Relationship (Type. Pro- Peter C. Remsen/Bro	ther	39:	Mailing Address (Street: 38 West Sho isposition (Name of			ater	or Town, State, Zip Code) , MD 21037 cocation - City or Town, State		
t. Page tment or tant: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Senteral Service Licensee	al from State cen	netery,	crematory or other place ncoln Ceme	tery 2/	13/2009	Bre	ntwood, Maryland las Funeral Home		
Dermi Depar Impor any ir		23a. Part 1. Enter the disease, or complication	s that caused the death	Do not	2973 Solom	ons Isla	ınd Rd.,I	Edge	water, MD 21037		
Physician /Medical		shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	se on each line.	950	elevotie	1 6			Interval Between Onset and Death		
s be executed string and sician and in burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):									
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. Whe Funeral Director: After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be detached for use as the t	Physician/Medical	in the past 12 months?	yes, outcome of pregnanc □ Live birth 2 □ Fetal d □ Pregnant at time of dea □ Unknown	eath	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	y			23d. Date of delivery Month Day Year		
requires that een signed b	à	Part II office significant conditions contributions	ng to death but not resulti	ng in th	e underlying cause give	en in Part I.			use contribute to the cause of death?		
n: The law rificate has b	Completed	25. Was case referred to medical					1 ☐ Yes	psy ormed? 2 \(\frac{1}{2}\)	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
g Physicia genthis cert ieral directo	n: To Be	examiner? 1 Yes 2 No Hospita 27. Manner of Death 28a	1 Inpatient 2 XE	R/Outpa 8b. Tim		er: 4 🗆 Nursing	eath (Check only of Home 5 Resinded Resinded Resinded Resonance Re	dence	6 ☐ Other (Specify) Iry occurred		
l or Attendin after death. Director: Af d in by the fur	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - At hom- building, etc. (Specify)		M 1 🗆	Yes 2 □ No	28f. Location (City or To	Street al	nd Number or Rural Route Number, e)		
n 24 hours n 24 hours te Funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: Call							s) and manner as stated. d place, and due to the cause(s)		
To the virthing committee of the committ	¥ (29b. Signature and title of certifier	20 pep	u + 1	29c, License D C	0605	4		ate signed (Month, Pay, Year)		
NOD		30. Name and address of person who completed the street of	ed cause of death (Item 2	3a) (Ty > re	pe, Print) 695	Iner	iea	21	035		
Sta Registra DHMH 17 Rev 1/20	ar	FEB 1 0 2009	32. Registrar's Signatur	1. 1	parke						

The law requires that the death certificate be executed Box 68760, o Division or Vital Records, P. or Attending 24 hours a Hospital

Maryland 21215-0036

Baltimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1H-2 DR. ROBERT GUEDENET 21WYAND State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

DHMH 17 Rev 1/2001

KEEDYSVILLE, MARYLAND, 21756 DRIVE 32. R gistrar's Signature

and manner stated

29c. License number

D32518

29d. Date signed (Month, Day, Year)

301-432-2222

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Year George Gibson Russell, Sr. February 10, 11:16 a M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 8, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Days 1927 577-32-7129 81 Yrs Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4921 Bluebonnet Court 20853 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes XX No Specify: 3 ☐ Widowed 4 ☐ Divorced 1945-69 White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commander US Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Grayson Russell Amelia Helen Klausman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances B. Russell/ Wife 4921 Bluebonnet Court, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ★Burial 2 Cremation 3 Removal from State Feb. 14. Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of); Septic Due to (or as a consequence of). SEPSI Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

Physician /Medical Examiner

> use as attending p

signed by the a d be detached f detached

should should

page 2

this certificate

To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di

Physiclan:

certificate be executed physician and the burial-transi

P.O.

of Vital Records,

Division

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

Completed by

Be

Certification:

Medical

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat a ust be notified at

tal Hygiene.

h and Mental F is marked ot

item 27 i

Department of Important: If its any Injury or o once.

Pages 1 :

be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

1 □Yes 2 🗷 No 26. Place of Death (Check only one)

2 No 1 ☐ Yes

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

Hospital: 28a. Date of Injury (Month, Day, Year)

and manner stated

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

29b. Signature and title of certifier

00062435

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (SAYED ELSAYYAL) (O) O NOLO Molecular D. Rockville, MD 20850

State Registrar

+1 10

31. Date filed (Month, Day, Year)



09-01196 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Juliette Rayner 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 9, 2009 Year 2357 hrs Medical Examiner Juliette Nancy Rayner 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Baltimore** University Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Foreign Country) Hours Months Days Aug. 31, 1939 Director 516-42-6114 69 Montana 2XF М Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a, State 10b. County 1 Yes 2 No Laurel Prince George's Maryland the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20708 LISA 11535 Laurelwalk Drive permit. Pages I and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a 14 Race - American Indian Black Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Yes White 1 Yes 2 X No specify: Divorced If Yes, Give Year Specify Widowed <u>م</u> or Dates 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Special Education Teacher PG Public School System Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Legato Martha Haidle Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ۵ 2206 Touchstone Court, Silver Spring, MD 20904 Wilfred John Legato/Brother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State or other tra 20a. Method of Disposition crematory or other place)

Dawson County Cemetery Feb. 18. 1 X Burial 2 Cremation 3x Removal from State 2009 Glendive, Montana Donation 5 Other Specify 22 Name and Address of Facility Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Medical Death a. Pneumonia Immediate Cause (Final disease .xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last andtransit The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ✔ Unknown Aplastic Anemia; Chronic Obstructive Pulmonary Disease; Hypertension; Malignant Completed 24a. Was an 24b. Were autopsy findings available Thymoma prior to completion of cause of autopsy death? certificate has performed? ✓ Yes 2 1 🗸 Yes 2 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be examiner's Hospital: 1 / Inpatient 2 Other' [ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other After this ဥ 1 V Yes funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural Yes 2 No Il Director: Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide or Town, State) determined within 24 hours a To the Funeral I Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 February 11, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Russell Alexander MD. State Registra OCME

1 - Sta 1. Dece

Physician /Medical

Examiner

Funeral

Director

Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at approximation of the provided Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any once.

Be Completed by Funeral Director

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Physician /Medical **Examiner** within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

29b. Signature and title of certifier

2/15/09

R 980/ Georgia Ave Suit 3-32 Silver pring 10 20902.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

D43446

29d. Date signed (Month, Day, Year)

2/15/09

09-01255	

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		30. Name and address of person	i who combleted cau	se or death (Iten	II Z38)					
		Russell Alexander MI		Medical Exar	niner 111	Penn Street	t, Baltimore, I	MD 21201		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 9 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2 **Physician** CONSTANCE JCHUYLER 33UM COOK 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 2, 9. Birthplace (State or Foreign 5. Social Security Number Days 1□M 2万F Hours Months 77 Yrs. Maryland 264-50-2118 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Anne Arundel Annapolis Maryland 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21409 205 Providence Road U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 200 Married 2 XX White 1 ☐ Yes 2 ☐ No Specify: ρ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Contract Specialist State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Alexander Cook Sybil Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print)

John A. Schuyler/husband 205 Providence Road Annapolis, Maryland Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/10/2009 Baltimore, Maryland Baltimore Crematory ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 147 Duke of Gloucester St., 21. Signature of Funeral Service Licensee Annapolis, MD 21401 John M. Taylor Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition

a. BASILAR ACTERY STRIVE Onset and Death Immediate Cause (Final disease or condition resulting in death) 40 Due to (or as a consequence of) LINKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Sam Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 ☐ No 4 🗌 Nursing Home 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 2 1 / Inpatient 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of

The law requires that the death certificate be executed burial-transit ec by the attending physician and detached for use as the burial-tran Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: after death. I Director: After t

Physician

/Medical

Examiner

Funeral

Director

Show

item 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. I program: If liem 21 is marked other than "natural", or flen eny Injury or other traumatic event

Baltimore, Maryland 21215-0036

death with the Maryland

completely filled in by the funeral dire Certification:

within 24 hours a To the Funeral I Medical State

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

1 Tes

29d, Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

woo completed cause of death (Item 23a) (Type, Print) Name and address of person. 441

31. Date filed (Mont)

5 Pending investigation

6 Could not be determined

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

1-

29b. Signature and title of ce

toant 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

1 1 2009

To Be Completed by Funeral Director

Physician /Medical

Examiner

Funeral

Director

_ State Registrar			Certificat	e of Death	Reg	J. No. 200	9 0625
Decedent's Name (First, Middle, Last					Date of Death Month	Day Year	3. Time of Death
Donald Frederic		sr.			February	7, 2009	4:00 P M
. Facility Name (If not institution, give) Woodward Court	street and number)		4b. City,	Town, or Location of Death	n	4c. County of Dea	
Social Security Number 6. Se	x 7. Age	(In yrs. last birti	nday) If Under	Annapolis 1 Year If Under 24 Hrs.	8. Date of Birth		Arundel thplace (State or Foreign
	XIM 2□ F	`	rs. Months	Days Hours Min.	(Month, Day,) April 11	rear) Co	ountry) lassachusett
ual Residence of Decedent State 10b. County		10c. City, Town	and anotion				10d. Inside City Limits
a. State aryland Anne Art	undel	Toc. City, Town	or Location	Annapolis			1XXYes 2 □ No
e. Street and Number 9 Woodward Court			10f. Zip	21403	100	g. Citizen of What Co	•
Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Deced	lent of Hispanic Origin? (S ify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:		1 □Yes 2				hite
15. Decedent's Edu (Specify only highest grad	ication fe completed)		Decedent's Usua (Give kind of wor	rk done during most of wor	king	6b. Kind of Business	/Industry
Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. DO NOT us echanica	al Engineer	1.	J.S. Gover	nment
Father's Name (First, Middle, Last)	-				ne (First, Middle, Ma		Anito II C
John William Sm	ith			Char]	lotte E. D	odson	
a. Informant's Name/Relationship (7) abbie M. Ramsey/o				(Street and Number or Ru			Zip Code) 2 1012
. Method of Disposition		20b. Place of l	Disposition (Nan	ne of ther place)	Date 20	c. Location - City or	Town, State
1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify,			nore Cre		/2009 B	N. 1 L J	Managara 7
				indicory ; 2/ 11	/2009 E	Baltimore,	Maryland
. Signature of Funeral Service Licens	see		22. Name an	d Address of Facility Jo	ohn M. Tay	lor Funer	al Home
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

DHMH 17 Rev 1/2001

State Registrar 29d. Date signed (Month, Day, Year)

2/10/2009

Annapolis, Md.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 31 State of Maryland / Department of Health and Mental Hygiene 1- Registrar WCHD/SH 2/18/09 per VR 06259 Certificate of Death 1. Decedent's Name (First, Middle, Last) Seth Kriner 2. Date of Death Schnebly MFEBRUARY 13, YZOO9 **Physician** 12:04_M AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reeders Nursing Home Boonsboro Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 220-26-7432 X□M 2□F 81 Yrs May 27,1927 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Washington Clear Spring MD 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14706 Fairview Road 21722 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married spwhite 5-0036 1 ☐ Yes X☐ No Specify þ 3 ☑ Widowed 4 ☐ Divorced Completed marked other than "nature marked other the Medical" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2121 Elementary/Secondary (0-12) College (1-4or 5+) dairy farm Farmer 12th grade Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be find and Mental F Roy Smith Schnebly Bertha Kriner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trau William Schnebly 14735 Fairview Rd.Clear Spring, MD 21722 son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 16, 20c Location - City or Town, State Clear Spring, MD N Burial 2 □ Cremation 3 □ Removal from State St.Paul Cemetery 2009 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc 21. Signature of Funeral Service Licensee 23a. Part 1. Enter me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he it failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Vavc disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and is the burial-transit the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) P.O. ed by the a 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2XNo 3 Probably 4 Unknown 1 Tyes Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has le 2 autopsy page perform certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pendina within 24 hours after occ...
To the Funeral Director, Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 3∏ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my spirites. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29h Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063233 02/16/09 WSO 30. Name and address of person who completed cause of the state of the

16H-6 State

31. Date filed (Month, Day, Year)

SHAHID MAHMOOD,

32. Registrar's Signature

Registrar

of death (Item 23a) (Type, Print) NORTHERN AVENUE HAGERSTOWN, MARYLAND, 21742 301-733-4496

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Box 68760. P.0. Division of Vital Records,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Feb. 8, 2009 Grace Elizabeth Sutton 6:59a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Renaissance Gardens Silver Spring 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3 / 08 / 1920 Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days 1 □ M 2 🛛 F 218-38-9562 88 Yrs. Pennsylvania Director Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Silver Spring MD Prince George's 1 Tyes 2 No Director 10g. Citizen of What Country? items 23a or USA 3160 Gracefield Rd #3126 20904 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2XNo Specify: White Specify: 3X Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'na any Injury or other traumatic event, the Matic once. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) University of MD. Microbiologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Slottman Grace Hasscarl ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 26218 Charles Howell/Son French Creek, West Virginia Route 2 Box 44 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 2/12/2009 Beltsville, Md Chesapeake Crem 5 ☐ Other (Specify) 4 Donation Funeral Service Lig PHYMERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** Cerebrovascular accident weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Atrial fibbrillation weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ chronic obstructive pulmonary disease 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) assisted 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) Feb.9,2009 D24035 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 3160 Gracefield Rd Silver Spring, Md 20904 E.S.Machado MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 12 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Shirley Lillian SCHUMAN February PO, 2009 4:51 P M 4c. County of Death Montgomery 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bethesda Suburban Hospital 9. Birthplace (State or Foreign Country) 1922 Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 🗓 F 86 577-28-6262 24, Sept. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 X No Boyds Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20841 14212 Gate Dancer Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No !! Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: white 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Sacks Wolf Gerstein 19b, Mailing Address (Street and Number or Rural Route Number, City, or Town, Sigle, Zip Code) 14212 Gate Dancer Lane, Boyds, MD 20841 19a. Informant's Name/Relationship (Type. Print) Eugene Schuman, Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State King David Memorial Garden 02/12/09 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Si mature of Funera Sirv ce Licensee TO MEN INSKIPS HET WEW Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Said the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Examiner must be notified

items 23a

9

if Health and Mental Hygiene. item 27 is marked other than other traumatic event, The M

permit. Pages 1
Department of F
Important: If ite
any Injury or ot
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Completed

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

DIVIDIO OF VITAL RECORDS, P.O. Box 68760,

ı	disease or condition resulting in death)	a. Due to (or as a consequence of):	org fairer	6						
ical Examiner	Sequentially list conditions, if any, leading to himsulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of):	5 9							
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23	d. Date of delivery Month Day Year							
leted by Ph		ontributing to death but not resulting in the unde	erlying cause given in Part I.	1 ☐ Yes 2 🗷	contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available					
Comp			444.5	autopsy performed? 1 □ Yes Z □ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No					
Be	25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)						
2	1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA Other: 4 ☐ Nursing Ho	ome 5 Residence 6 [Other (Specify)					
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28d. Describe how injury occurred							
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street building, etc. (Specify)	, factory, office	28f. Location (Street and i City or Town, State)	Number or Rural Route Number,					
Medical O		niner: On the best of my knowledge, death or niner: On the basis of examination and/or inves and manner stated.								
Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

D66066

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leted cause of geath (Item 23a) (Type, Print), 8600 Old Georgetown Rd., Bethesda,

		1	For State Registrar	C	ertificate of Dea	ith	Reg. No. 200	06262
	Physicia	_	1. Decedent's Name (First, Middle, Last)	it	SHAW	2. Date of De Month	Day Year	3. Time of Death 0 7 0 7 M
	/Medic	al -	A. Facility Name (If not institution, give street and numbe	1	4b. City, Town, or Locat		4c. County of Dea	7 7 7
	Examin	er '	Hospice of the Chesapeake	,	Harwood	NOT OF BOWN	Anne Aru	
, a.y	Funeral		5. Social Security Number 6. Sex, '7. A	ge (In yrs. last birthda	(av) If Under 1 Year If Un	nder 24 Hrs. 8. Date of Bi	th 9. Bir	thplace (State or Foreign
	Director		578-42-5960 12 M 2□F	77 Yrs.	Months Days Hou	Jan. 2	3, 1932 Was	hington, DC
	pur 🛦		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	r 28a-f show	. 1	Maryland Prince George's	Hyattsv				1⊠Yes 2□No
	28a-	- A -	10e. Street and Number	nyaccov	10f. Zip Code		10g. Citizen of What Co	ountry?
	3a or		5406 13th Avenue		20781		USA	
	death	Funeral	11. Marital Status 12. Was Deceder Armed Forces	t Ever in U.S. 1	Was Decedent of Hispanial If Yes, specify Cuban, Me:	c Origin? (Specify Yes or No	o- 14. Race - Ame Black, Whit	
õ	be filed within 72 hours after death with the Maryland tal Hyglene. id other than "natural", or items 23a or 28a-f show event, the Madical Even incompatible actified at		1 Never Married 2 Married 1 X Yes 2 ☐] No		ecify:	Specify: W	
21215-0036	ural",	d by		1953–1955	cedent's Usual Occupation		16b. Kind of Business	
<u>,</u>	n 72 l	Completed	15. Decedent's Education (Specify only highest grade completed)	(G	ive kind of work done during e. DO NOT use retired)	most of working		,
212	filed within Hygiene. other than '	E	Elementary/Secondary (0-12) College (1-4o	Me Me	chanical Engi	ineer	Federal Gove	rnment
פַ	be filed value tal Hygid other	BeC	17. Father's Name (First, Middle, Last)		1	Mother's Name (First, Middle		
<u> </u>	should be nd Mental marked c	욘	William Howard Shaw			illian Cather		
Maryland	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print)	- I	ailing Address (Street and N			Zip Code)
<u>ر</u> ک	and lealth m 27 her tr		Kathleen O. Pessagno / Daught		Lowery Road	, Huntingtown	20c. Location - City or	Town, State
Baltimore,	iges 1 or of h		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State		sposition (Name of crematory or other place) Veterans Cemeter	1	Cheltenham	
<u>=</u>	iit. Pa artmer ortant injury	i	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligenses 7	Maryland	22. Name and Address of F	- 1		
Ba	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.	18	and It the	0	Gasch's Funer	al Home, P.A	. Hyattsvil	imore Avenue Le, MD 20781
			23a Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ngestin	Heartfarder Hz F	is acute on	Olikonic	Onset and Death
	/Medical		resulting in death)	nsequence of):	0 11 1	ب بر ماد ماد		1000
	Examiner	L	Sequentially list conditions, b.			an ten from		gears
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	is a consequence of):	1):			
ь.	execut and al-trar	Examiner	that initiated events c	as a consequence of):				
68760,	eath certificate be executed attending physician and for use as the burial-transit		L d.					
9	tificat ng phy as the	ledical						
Box	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birtl		3 Ectopic pregnancy		23d. Date of de Month	elivery Day Year
о Ш	e dea the at red fo	Physician/N	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	t at time of death า	5 Other (specify)			
P. 0.	res that the de signed by the a be detached f	Phy	Part II. Other significant conditions contributing to deat	but not resulting in th	ne underlying cause given in I	Part I. 23e. Did	tobacco use contribute	to the cause of death?
Division of Vital Records,	uires t signe d be	d by	Denente	~			Yes 2□No 3□F	Probably 4 Unknown
200	w req	Completed				24a. Wa	s an 24b. Were a	autopsy findings available
Re	The lar te has age 2	ошо				aut per 1 □ Yes	formed? death?	
ta	an: Triffication, po	Be C	25. Was case referred to medical		26.	Place of Death (Check only	one)	
>	nysici nis ce direc		examiner? 1 Yes 2 No Hospital: 1 Inp	atient 2 ER/Outpa	atient 3 DOA Other: 4	☐ Nursing Home 5 ☐ Re	sidence 6 Other (Sp	ecity) HOSPICE
n o	ng Pl	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of (Month,	njury 28b. Tim <i>Day, Year)</i> Inju	ıry Work?	1	how injury occurred	1)0410
sio	vttendi death. ctor: / y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of	Injury - At home, farm	M 1 ☐ Yes		(Street and Number or I	Ruml Route Number
Ξ	or Attendafter death Director:	Certification: To		etc. (Specify)	, street, factory, office	City or To	own, State)	iarai riodio ridinosi,
_	spita nours neral y fille		29a. Certifier 1 Certifying Physician: To the beautifier (Check only 2 Medical Examiner: On the basi	est of my knowledge, o	death occurred at the time, d	late and place, and due to the	ne cause(s) and manner	as stated. ue to the cause(s)
	the Ho hin 24 t the Fu mpletely	Medical	one) and manner	stated.			OOL Date dans I (Man	th Day Veed
	No To Con Con Con Con Con Con Con Con Con Co		29b. Signature and title of opertifier	Aum	1 2 ac. License flui	1438	Fohnuan.	1/3 Auria
	1.1		20. Name and address of parces of formulated acres	of death (Item 23a) (Ti	/pe. Print)	1	J De la Coma	70007
R	1+1		30 Name and address of person who completed cause of the complete cause of the caus	, 441 DE	FENSE MAHO	VAY HNNAPUL	g MO VIYU	/
	Sta Regist		31. Date filed (Month, Day, Year) 32. Reg	strar's dignature				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month WOW 2009 February /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Spring Montg Brooke Grove Rehabilitation and NUISing Center Sandy If Under 1 Year | I Under 24 Hrs. 9. Birthplace (State or Foreign Country) Illinois 5. Social Security Number 6. Sex 7. Age (In yrs. last bilthday) **Funeral** Months Hours Year) 1 □ M 2 T F Jan. 346-12-2642 12, Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat her notified at once. 1 ☐ Yes 2 No Directo Maryland Montgomery Brookeville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22341 Flintridge Drive 20833 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: ģ If Yes, Give Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wendelin Hanson Margaret Heinz မ 19b. Mailing Address (*Street and Number or Rural Route Number, City or Town, State, Zip Code*) 22341 Flintridge Drive, Brookeville, MD 20833 19a, Informant's Name/Relationship (Type. Print) Terence Tuohy/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory Feb. 10, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis Address Collyins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) GAST ROINT **Physician** DA45 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy Month Year 5 Other (specify) P.O. I 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed' 1 ☐Yes 2 ☐ No 1 □Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director; After this filled in by the funeral d 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred **Division** 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certified

State Registrar MD 18100 Stade School Road, Sandy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Grace Brook Huffman
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Ĭ1, 2009 1:55 PM Mary Elizabeth Toledo 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery 9739 Hedin Drive Silver Spring 9. Birthplace (State or Foreign Country) 1958 Washington, D.C. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 22, 5. Social Security Number 7. Age (In yrs. last birthday, Hours Days 1 □ M 2 🗓 F 217-84-8356 50 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20904 USA 13917 Castle Blvd. #33 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Daycare Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Eleanor Wollett Harry Aloysius Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13917 Castle Blvd. #33 Silver Spring, MD 20904 Kelly Ann Toledo/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State W. Arundel Crematory 02/13/09 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. Colon Cancer with Metastases vears Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) I∐Yes 2⊠No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐Yes 1 ☐ Yes 2√ No

Physician /Medical Examiner

and

attending physician

certificate

P.O. Box 68760

Division of Vital Records,

Physician

Examiner

Funeral

Director

28a-f show

Directo MD

Funeral

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Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be retified at once.

Baltimore, Maryland 21215-0036

the Maryland

/Medical

10a. State

Examine the burial-transi signed by the a d be detached for icate has been sig , page 2 should b 24 hours after death.

Funeral Director: After this certifical tilled in by the funeral director, I

9 Unknown 25. Was case referred to medical examiner?

29a, Certifier

Physician/Medical ≥ Completed Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed To the Hosp within 24 hou To the Fune completely fi

1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 ☐ Suicide

6 ☐ Could not be determined 4 ☐ Homicide

Hospital:

28b. Time of 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 6 Hother (Specify) home 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

26. Place of Death (Check only one)

29b. Signature and title of certifier

D33224

29c. License number

29d. Date signed (Month, Day, Year) February 12, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ram S. Trehan, M.D. 1400 Forest Glen Rd. #435 Silver Spring, 31. Date filed (Month EB

State Registrar

Medical

egistrar's Signature

09-00627	
Charles Thomas	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

o momac		1- For State Registrar	Certi	ificate of De		, Reg. N	o. 2 N	09 0626
Physici	an/	Decedent's Name (First, Middle,La		-	33.5.19.	2. Date of Death Month Day January 21, 2	Year	3. Time of Death 1300 hrs
al Exami	mer	Charles 4a. Facility Name (if not institution, gi	Robert		IOMAS ty, Town, or Location of Dea		4c. County of Dea	
		17796 Garland Gr				stown	Washington	
*** Funeral		5. Social Security Number 6. S		st birthday) If				Birthplace (State or Foreign
Director		219-82-2354 1	X _M 2_F 43	Yrs. M	onths Days Hours N	^{lin.} 06/03/19	65 M	country) aryland
any		10a. State 10b. County	10c. City, T	Fown or Location	***			10d. Inside City Limits
*	<u> </u>	MD Alle	gany	Cumberl	.and			1 Yes 2 XNo
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number		10f	. Zip Code	10g. C	citizen of What Co	ountry?
a or 2	ä	10419 Cave	Street, NW		21502		USA	
ms 23 be no	eral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue		14. Race - Am White, etc.	erican Indian, Black,
2 should be lifed within 72 hours after death with the Maryland 1 and Mental Hygis: e. 1 is userked other than "natural", or items 23a or 28a-f she munatic event, the Medical Examiner must be notified at once.	Funera	1 Never Married 2 X Marrie	1 X Yes 2 No			no racan, etc.,		
aner ral",	J. J.		ed if Yes, Give Year or Dates:		2 X No specify:		Specify:	White
nour:	ed	15. Decedent's Education (Specify	College (1-4 or 5+)		sual Occupation (Give kind of working life, DO NOT use of the control of the cont		. Kind of Busines	s/industry
III /2 han '	ble	Elementary/Secondary (0-12)	College (1-4 of 5+)	Manage	er		Restaur	ant
gir: c ther	Completed	17. Father's Name (First, Middle, Las	st)		18.Mother's Na	me (First, Middle, Maid	en Surname)	
ked o	Be	Charles	Russell	Thom	nas Delor	es D		Rainey
ages area 2 should be in nt of Heal it and Mental I t: If item it is marked other traumatic event,	2	19a. Informant's Name/Relationship	(Type, Print)		ress (Street and Number			
ome i		Teresa L. Thoma			Cave Street,			
FHeal Fitch		20a. Method of Disposition 1 Burial 2 X Cremation 3		lace of Disposition rematory or other p	(Name of cemetery, ace)	Date 20	c. Location - City	or Town, State
permit. Tages Larve 2. Department of Health Purportant: If iton- injury or other traum		4 Donation 5 Other Specia	Can		Crematory 02	/25/2009	Cumberl	and, MD
partin porta		?1. Someture of Funeral Service Lice		22. Name	and Address of Facili: A	dams Family	Funera	l Home, P.A.
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ysician		Ja. Part h Ental the disease, or con failure. List only one cause on					shock, diffee	Approximate Interval Between Onset and
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		or condition resulting in death)	Due to (or as a consequence of)):				
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ate be hysicia ie buria	Medical	IF FEMALE:	23a, 27, 2		ME, g891 5/1		23d. Date of deliv	erv
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The licate page	5					1 ✓ Yes 2	No 1 🗸	
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Physic rthis aldir	0	1 ✓ Yes 2 No	I Inpatient 2 t	ER/Outpatient 3			idence 6 🗸 Ot	her: Scene
ling Ph After t funeral	ü	27. Manner of Death 1 Natural 5 Pending	(Month, Day, Year)	28b. Time of Injury	4 Ty., 6 Y y.	28d. Describe how unk	injury occurred	
Attend death sctor: by the	cati	2 Accident Investiga	ation Fu 1/21/09	Fd 1300	nr _s —	006 1 222122 (0122	at and Number or	Rural Route Number, City
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ospits hours intera		4 Homicide	(0,000))	o dooth occurred	at the time date and place			
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending I compoletely filled in by the funeral director, page 2 should be detached for use as the content of the content o	Medical	Check only Certifying Phys	ician: To the best of my knowledgener:On the basis of examination an	e, death occurred and/or investigation,	in my opinion, death occurre	and due to the cause(s) ed at the time, date and	place, and due to	the cause(s)
To To I	Med	29b. Signature and title of certifier	and manner stated.		29c. License number		ld. Date signed (/	
		inno	THIN		O.C.M.E.		anuary 22, 20	
		30. Name and address of person wh	o completed cause of death (Item:	23a)				
		Russell Alexander MD.	Assistant Medical Exami		nn Street, Baltimore,	MD 21201		
9	State	31. Date filed (Month Day)	32. Registrar's Signatur		no s			
Regis			1	Fr. French			ME	
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			For State Registrar	State of	Marylan		artmen rtificat			and M	ental Hyç	giene Reg. No.	000		
-75	Physicia	an	1. Decedent's Name (First, Middle	e, Last)							2. Date of Dea Month	Day	Year	3. Time	Death (
	/Medic	al	Ruth T. Updack 4a. Facility Name (If not institution	n dive street and num	her)		4h. City	Town or	Location of	of Death	rebruar	y 6, 200	nty of Death	11	ra IVI
4	Examin	er	Crescent Cities Ad			er		River					ce Geor	ge's	
	Funeral Director		5. Social Security Number 579–32–8905	6. Sex 7 1 ☐ M 2 1 F	. Age (In yrs. 89	last birthday) Yrs.	if Under Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Birth (Month, Day May 19,	/, Year)	9. Birth	place (State ntry) Texas	or Foreign
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside C	city Limits
	Maryla f shov	JO.		e George's	100. 01.	River									2 ⊠ No
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	ath wit	ralD	4409 East West H				20737				USA				
36	be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If Yes Give	ces? 2. [X] No		Was Dece If Yes, spe 1 □ Yes		ispanic Ori in, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	o- 14. Race - American Indian, Black, White, etc. Specify: Black			
Maryland 21215-0036	in 72 hou n "natura Aedical E	Completed	(Specify only highe	nt's Education est grade completed)	Apr.F.)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	al Occupa rk done d se retired	ation during mos)	t of worki	ing	16b. Kind of		•	
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Mary	C = 44 F		19a. Informant's Name/Relations Tim Traylor/Nephe			19b. Mailir	-	•			al Route Numbe e, Silver				
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יסר	ig Phy ter this neral d	<u> </u>	27. Manner of Death	28a. Date o	·	28b. Time o		28c. Injur Worl			28d. Describe			<i>ny)</i>	
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Division or Vital	tal or Attenders after death al Director: ed in by the	Certification:	4 Homicide determ	mined 200. Flace	of injury - At h	ome, farm, st	reet, factor	y, office			28f. Location (i City or Tou		mber or Rui	ral Route Nu	mber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		ing Physician: To the li i Examiner: On the ba and mann	sis of examina										(s)
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			30 Name and address of person	who completed cause	of death (Iter	n 23a) (Type,	Print)	2005	bur	کر ا	21 Fixe	Tebrua TRV	The P	MD 2	551
	Sta Regist		31. Date filed (Month, Day, Year FEB 12	2009 June	egistrar's Signa	ature	Kis				1				
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Registrar DHMH 17 Rev 1/2001 09-01128 Mary Van-Gilder

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day February 7, 2009 1416 hrs Medical Examiner Mary VanGilder c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Crownsville 1329 Woolly Way 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country) Months Days Hours Director 562-36-4749 WVA 3/20/1911 97 M 2 XF Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Yes 2 X No 28a-f show Crownsville or items 23a or 28a-f shomust be notified at once Anne Arundel Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21032 1329 Woolly Way 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. Armed Forces? 1 Never Married 2 Pages 1 and 2 should be filed within 72 hours after death Married Yes 2 X No Yes 2 X No specify: White 3 X Widowed Divorced Yes, Give Yee nt of Health and Mental Hygiene.

1: If item 27 is marked other than "natural", other traumatic event, the Menical Examiner ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Homemaker MD 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Lonski John A. Garay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1329 Woolly Way Crownsville, MD 21032 Jerome Myers 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Cremation 3 Removal from State Burial 2 2/18/09 North Hollywood, CA ment lant: or ot Valhalla Memorial Par Donation 5 X Other Specify: Entombment 22. Name and Address of Facility Hardesty Funeral Home, P.A. permit. 21. Signature of Funeral Service Annapolis, ML 21401 Ridgely Ave. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or hea Approximate Interval Physician Between Onset and failure, List only one cause on each line Death Medicar a. Congestive Heart Failure Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of) b. Hypertensive Atherosclerotic Cardiovascular Disease Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed nysician/Medical UNPENDED AMENDED ysician a Hospital or Attending Physician: The law requires that the death certificate be to the hours after death. 23d. Date of delivery Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy attending phys for use as the b Year 3 Ectopic pregnancy Month 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 V No 9 Unknown Unknown the signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No 3 Probably 4 ✔ Unknown Yes 2 ğ Completed 24b. Were autopsy findings available 24a. Was an peen prior to completion of cause of autopsy death? performed' certificate has 1 🗸 Yes Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other; lospital: Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 ✔ Yes No After this 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending Director: the 2 Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc in by 3 Could not be or Town, State) Suicide determined 24 hours a Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 8, 2009 O.C.M.E. Un who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year, Registra

ORIGINAL

		1	For State Registrar	state of Mar	yland / Depa <i>Cer</i>	rtificate of E			. No. 2000	06060
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	/Medic Examin		4a. Facility Name (If not institution, give stre Riva Terrace Assist	eet and number)		4b. City, Town, or Riva	Location of Death		4c. County of Death Anne Arund	le1
	Funeral Director		5. Social Security Number 6. Sex 1 □ M		Yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y) Jan. 3,	(ear) 9. Birthp 1915 Neth	place (State or Foreign ntry) erlands
	Maryland -f show	.	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arund		Oc. City, Town or Lo				1	0d. Inside City Limits 1 ☐ Yes 2 📉 No
	h with the 23a or 28a	ਙ∣	10e. Street and Number 1006 Sextant Court		·	10f. Zip Code 21401			J. Citizen of What Cour USA	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Examinst must be notified at once.	by Fui	11. Marital Status 12. 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Was Decedent Even Armed Forces? 1		Was Decedent of Hi fYes, specify Cuba 1 □Yes 2 [™] No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
21215-0036	within 72 hor ene. than "natur in Medical I	Completed	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12)	ion ompleted) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired Dedic Tech	luring most of work)	ing	sb. Kind of Business/In Medical/Hea	
	ild be filed fental Hygi rked other tic event, II	To Be Co	17. Father's Name (First, Middle, Last) Wilhelm Nieuwenhui	zen	101 0110		18. Mother's Name	e (First, Middle, Ma van Koote	iden Surname)	
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Baltimore, Maryland	it. Pages 1 rtment of H rtant: If iter njury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee		20b. Place of Disponsion Ceretery, creating Kalas Cre	ematory	2/12	/09 Ed	lgewater, M alas Funera	Maryland
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of Vital Records,	Th ate pag	Completed						24a. Was an autopsy perform 1 □ Yes 2	prior to condeath? No 1 Yes	opsy findings available ompletion of cause of
Division of Vita	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 1 Noticide 6 Could not be determined	28a. Date of Injury (Month, Day,	t 2 ER/Outpatie (Year) 28b. Time of Injury y - At home, farm, st (Specify)	of 28c. Injur Worl M 1 🗆	er: 4 □ Nursing H	28d. Describe hov	oce 6 Other (Spec vinjury occurred eet and Number or Rui	Living
Ω	e Hospital of 24 hours at Eruneral Dietely filled i	edical Ce	29a. Certifier (Check only one) CertifyIng Physic 2 Medical Examine one)	cian: To the best of er: On the basis of and manner state	examination and/or in	th occurred at the ti nvestigation, in my o	me, date and place opinion, death occu	e, and due to the ca rred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and the oncertifier		-	29c. Licens	36761	/ 29	d. Date signed (Month	, Day, Year)
	SH	ate	30. Name and address of person who com Michael Riebman, M. 31. Date filed (Month Day Year) FEB 1 200	D. 2448	Holly Ave	. Annapol:	is,MD. 21	401		
	Regist	rar	LCD 1 1 500	13 Deneu	N B. A	arked				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death Day 4:34 PM February 8 2009 Aliceteen E. Wade 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Heritage Harbour Health & Rehab Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Month, Day, May 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Months 1 □ M 2**X** F Maryland 90 219-12-3513 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Anne Arundel 1X Yes 2 □ No Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 USA 911 Carrollton Ave 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □Yes 2√∑No Specify: Specify: Black 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Sears Elementary/Secondary (0-12) College (1-4or 5+) Department Store 0 Shipping & Receiving 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pearl Boston Harry G. Simms 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1522 Ringe Dr. Severn, Md. 21144 Patricia Edmond(Grandaughter) Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Thace of Disposition (Name of cemeter), crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 XOther (Spe Montombment Memorial Gardens 2-13-09 Annapolis, Md. Mame Reads of Secilisons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions 23d. Date of delivery Month Day use contribute to the cause of death? No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

nd Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, In Many injury or other reaumatic event, In Many Gince.

the Medical Examiner must be notified at

Director

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Completed

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Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed and n 24 hours after death.

Be Funeral Director: A sletely filled in by the f

Division of Vital Records, P.O. Box 68760,

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Part II. Other significant conditions of the Con		sulting in the underlying cau	se given in Part I.		ase contribute to the cause of No 3 Probably 4 24b. Were autopsy finding prior to completion of death? 1 Pes 2 No] U
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examiner? 1 ☐ Yes 2 ☑ 📆	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient 3 ☐ DOA	Other: 4 Norsing	Home 5 ☐ Residence 6	6 ☐Other (Specify)	
27. Manner of De 5 Pending Investigatio	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	lnjury at Work? 1 □Yes 2 □ No	28d. Describe how injury	y occurred	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory, c	ffice	28f. Location (Street and City or Town, State,	d Number or Rural Route Nu)	ımt
	hysician: To the best of my kn miner: On the basis of examin					e(s)

and manner stated

Registrar

29b. Signature and title of certifier

31. Date filed (N

within 2

License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Williams Donald 1655 /Medical 02 08 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park 111

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months Days | Hours | Min. | 07/23/1953 Montgomery Hosp. Let 5. Social Security Number Adventust Birthplac Country) VA ge (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 1 X M 2 ☐ F **Funeral** 215-48-8392 55 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It will fill a first instructional by notified at Director 1X Yes 2 □ No Prince Georges MD University Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4100 Underwood Street 20782 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White <u>გ</u> Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Senior System Programer Arlington County Govt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Williams Sylvia Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Williams - Wife 4100 Underwood Street University Park MD 20782 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 X Removal from State National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 02/13/09 Falls Church, VA 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc
1091 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): Artisy /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physicians the burial P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) detached 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown Completed director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) anu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB

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7600

Carrell

Huspital's Signature

Adventist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9:20 AM 15. 2009 WILMORE February MOZELLE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's 7213 Mt. Forest Terrace Forestville 9. Birthplace (State or Foreign Country) District If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 16,1944 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 1 □ M 2 🗓 F 579-56-6996 Mar. Columbia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Market Examinar must be nutther an once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 vYes 2 □ No Maryland Prince George's Forestville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20747 USA 7213 Mt. Forest Terrace Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □ X If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: Black 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Staffing Specialist Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Be Battle Marie Covington McKinley McKinley ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gloria Bouknight, Sister 7213 Mt. Forest Ter., Forestville, MD 20747 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 02/23/2009 Bladensburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jordan Funeral Service, Inc. 4001 Benning Rd., N.E., Washington, DC 20019 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** mo /Medical Due to (or as e conse dence of): **Examiner** Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☒ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) n 24 hours after be Funeral Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 32. Registrar's Signature

OLD BRANCH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6104

completely

(Check only

29b. Signature and title of dertifier

SOHN LEE

7 2009

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

0,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ++00 ebruig 2009 Wark /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery General Hospital 01nev Hours Min. 8. Date of Birth (Month, Day, Nov 25, Birthplace (State or Foreign Country) If Under 1 Year Social Security Number 6. Sex 1 🛣 M 2 🗆 F 7. Age (In yrs. last birthday) **Funeral** Months Days 1942 Washington, 66 577-56-6173 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Madical Ever in continual be notified a once. 1 X Yes 2 No Montgomery Rockville Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20853 United States 5314 Crestedge Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 秦☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. <u>ک</u> African American 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Pastry Chef 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beatrice Dunmore James A. Washington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5314 Crestedge Lane Rockville, MD 20853 Morine Rose Washington - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory Feb. 23, 2009 Clinton, MD 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service 4001 Benning Road, NE Washington, DC 20019 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C se (Final disease or condition resulting in death) **Physician** Metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No ned by the 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 No 2 No 1 TYes 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 X Natural 5 ☐ Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

31. Date filed (Month, Day, Year) State 17 2009 Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

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	Negistal			2. Date of Dear	th		3. Time of Death				
	Physicia		Richard G. Yo	ung				Month Feb.	06, 2	1009 Year	8:30 P M
	/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Death			ty of Death	
			Anne Arundel Me	dical Center		Annapo				Arun	
	Funeral			6. Sex 7. Age (li 1X M 2 □ F 72	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	Coun	
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	land ow		10a. State 10b. County		c. City, Town or Lo					1	Od. Inside City Limits
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	h the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Coun	try?
	23a (교	1164 Bacon Ridg	e Road		21032			USA		
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13. \	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sj an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		ace - Americ ack, White, e	
36	or it	by F	1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 Mayes 2 □ No If Yes, Give Year or Dates:	40.00	1 □Yes 2 X No	Specify:		Spec	_{ify:} Whi	te
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yla	should be and Mental marked o	유	Russell P. You					·		- 04-4- 7:-	Octo
Mar	12 sho th and 7 is ma trauma		19a. Informant's Name/Relationsh Wendy V. Young/				and Number or Ru .dge Road				
e,	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items and the notified at other traumatic event, the Madeal Evention of the notified at		20a. Method of Disposition		20b. Place of Dispo				20c. Location		
õ	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.	1	1 ☐ Burial 2 ☐ Cremation	3 A Removal from State			1		7.70 to 20th	or mo 1	NTS .
Baltimore,	permit. P Departme Importan any injur once.		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		Watertown				Watert		eral Home
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			a. Part . Enter the disease, or s ck, or heart failure. List	omplications that caused the	e death. Do not ent	ter the mode of dyi	ng, such as cardiad	or respiratory an	rest,		Approximate Interval Between
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1	/Medical		resulting in death)	Due to (or as a co	onsequence of):	11.0	J				
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	ted isit	Examiner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	Drie to (or as a	indorph	tial 1	Jelmon	aus -	I low	ses	
	execu n and al-trai	Xar	that initiated events resulting in death) Last	c	onsequence of):			-0	7 - 5,70		
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89	tificat ig phy as the	ledi									
Вох	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		☐ Ectopic pregnanc	cy			ate of delive	
О.	e dear	sick	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at tin 9 ☐ Unknown		Other (specify)				NOTHI	Day Year
<u>Ч</u>	uires that the de signed by the a d be detached f	Physician/Me	9 ☐ Unknown Part II. Other significant conditio		not resulting in the u	nderlying cause giv	ven in Part I	23e. Did to	bacco use co	ntribute to th	ne cause of death?
Ś.	ires the signer signer of the d	ğ	Lunsten	5 1 DW	iot resulting in the a	nacitying caabo gi		1 □ Y	es 2□No	3☐ Prob	pably 4 ☐ Unknown
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5	/sicia s cert directe	o Be	examiner? 1 ☐ Yes 2 1 No	Hospital:	2 ☐ ER/Outpatie	nt 3 □ DOA Oth	ner:	lome 5 ☐ Resid		ther (Specif	iv)
Division of Vital Record	g Phy ter thi neral o	ű	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Inju	ry at	28d. Describe h	ow injury occi	urred	
Ö	endin sath. or: Af	atio	1 Natural 5 Pending 2 Accident investig	ation		M 1 🗆	Yes 2□No				
<u> </u>	r Atte	Certification: To	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi		 At home, farm, str (Specify) 	reet, factory, office		28f. Location (S City or Tow	Street and Nur n, State)	nber or Rura	al Route Number,
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier	g Physician: To the best of r Examiner: On the basis of ea and manner stated	xamination and/or in	nvestigation, in my	opinion, death occi	e, and due to the urred at the time,	date and plac	e, and due to	the cause(s)
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner states	<u> </u>	29c. Licen	se number		29d. Date sigi	ned (Month,	Day, Year)
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7	26x, K		30. Hamalan ress if erson	ho omplete cause f deat	th (Item 23a) (Type,	Print) Adm	7001	Made.	call	Huy	
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	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	ball			,		
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Februario 3:28A Baby Girl Ayres 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, **Funeral** av. Year 1 □ M 2 🔀 F Days Feb 20, 2009 Maryland infant Director Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits show unk must be notified at Temperanceville 1 ☐ Yes 2X No Director 28a-f VA 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? items 23a 25417 Saxis Road 23442 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status item 27 is marked other than "natural", or itelether traumatic event, the Medical Examiner 1 XNever Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: black Specify. 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) infant infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Calvin Lewis Ugatha Ayres ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) in state 21. Sign ture of uneral Service Lice Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Part . Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line. Baltimore, MD 21201 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate use (Final disease or condition resulting in death) **Physician** Due to (or as a consequent of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami The law requires that the death certificate be executed use as the bunal-trai that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? ţ Month Year Day Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 2 No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) al or Attending Physics after death.
I Director: After this ce of in by the funeral directors. မ 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide Hospital 29a. Certifier (check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatur# and title of certifie 29c. License number -000 30. Name and address of person Renneth J. who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06275 State of Maryland / Department of Health and Mental Hygiene ? 1 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1218 A M Anthony MARCH-1 Evelvn Ester 2009 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number 4c. County of Deat Examiner CLENBURNIE BARTIMORE WASHINGTON MEDICAL AMNE UNISE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
March 27,1939

| 9. Birthplace (Seale of Country) | Puerto Rico Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 MF 582-68-2435 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 1 ☐ Yes 2 ☐ No Examinar must be notified Director MD Anne Arundel Severn 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code ö 1914 Foxhound Court 21144 U.S.A. items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 72 hours after 1 Never Married 2 Married ō Specify: Hispanic Specify: Puerto Rican Baltimore, Maryland 21215-0036 1K Yes 2 No If Yes, Give Year or Dates 2 3 M Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. Iem 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) MD School for the Deaf. Principal Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Natividan Santiago Angel Figueroa ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Healt, Important: If item 27, any injury or off-662 Shore Road Severna Park MD 21146 Mr. Gerald T. Anthony Jr./Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Crownsville, MD Maryland Vets Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARUNOMA SATHE **Physician** LETATTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). physician and the burial-transit or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown atter for u 3 Ectopic pregnancy Dav Year 5 Other (specify) the signed by the 9 DlJnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed certificate 1 ☐ Yes 2 No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. filled in by the f 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a

To the Funeral C

completely filled

of Vital Records, Division the Hospital

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State Registrar

DHMH 17 Rev 1/2001

Medical

29a, Certifier

29b. Signat

and manner stated.

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who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

tospital

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D45149

29d. Date signed (Month, Day, Year)

Wise Gren Burne MD 20161

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death A 2. Date of Death EBRUARY Pay 28. **Physician** Year 12:50M Michael Harold Arfaras /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Saint Joseph Medical owson Cente If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ₹ M 2 □ F Director 362-70-7226 March 22,1957 Michigan Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it of Medical Examinar must be notified at 1 ☐ Yes 2 【YNo Director Maryland **Baltimore** Parkville with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7909 Elmhurst Avenue 21234 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iter 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ģ 3 ☐ Widowed 4 ♥ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Automobile Elementary/Secondary (0-12) College (1-4or 5+) Finance Officer Dealership 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any linjury or other traumatic evonce. ၉ Nicholas John Arfaras 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James B. Taylor Brother 2125 Collins Shelby Township, Michigan 48317 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hillton Service Corp. 3-3-2009 Towson Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Sign Towson, Maryland 21204 1050 York Road Approximate Interval Between Onset and Death E MONTHS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** METASTATIC LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner be executed and resulting in death) Last Due to (or as a consequence of): physician at the burial burial Box 68760 Physician/Medical The law requires that the death certificate attending p IF FEMALE 23c. if yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a o 1 Tyes 2 No. 9 Unknown ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy performed? Yes 2 No certificate 2 No 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) After th 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Division 1 ☐ Yes 2 ☐ No death. 2 Accident Director: d in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n HEI OII M. D.

32. Pegistrar's Signatur 7601 OSLER DRIVE, TOWSON. MARYLAND 21204 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** FEBRUARY 15, 12:55 P ^M HILDA BORYS 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖸 F Mar 22, 89 1919 Pennsylvania Director 184-14-9289 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notifled at 1 Yes 2 No Director MD Baltimore White Hall the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19606 Old York Road 21161 USA Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours afternent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or itelizy or other traumatic event, the Medical Examiner. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white Completed by Specify: 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unk unk supervisor bethlehem steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ellen Powell William Henry Gregory 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Huffman/daughter 7561 rock Jim Road Stewartstown, PA 17363 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If ite any Injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses Ronald S. Wage State Anatomy Board 655 W. Baltimore Street Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, at heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician cereb /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 2 🗆 No 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4N Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 03553 17 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

615 W. MACPHAIL ROAD 31. Date filed (Month, Day, Year) MAR 03 2009

BEL AIR, MD.

21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 5, 2009 **Physician** 1:00 AM M Carolyn Bolden /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Hvattsville Heartland of Hyattsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) June 28, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Min Hours 1 ☐ M 2 😾 F 1947 61 Director 577-60-8081 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Prince George's MD Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 20782 1414 Ray Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: black Be Completed by 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk clerical sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Heartland of Hyattsville 6500 Riggs Road Hyattsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or 4□Donation 5☑Other(Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade, Direct 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARDIOPULMONALY immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner UNG the death certificate be executed attending physician and for use as the burlal-trar Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Vear Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of 24a Was an has e 2 autopsy page death? 1 ∐ Yes certificate 2 □ No 1☐ Yes 2 NO or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient ٩ this After thi 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation Division Injury 1 Natural 1 TYes 2 TNo death. 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after To the Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WD

State

DHMH 17 Rev 1/2001

P.O. Box 68760.

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Registrar's Signat

of person who completed cause of death (Item 23a) (Type, Print)

OFYEITAKA 7325A HARLOVERPORTMY GREETBELL MARTLAND 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February **Physician** 2009 11:29 AMM Gunther Bienes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 ☑ M 2 □ F 064-24-3269 82 Director Feb 22, 1927 Germany Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ▼ No Director MD Harford Havre de Grace 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4125 Webster Road 21078 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1∑IYes 2 □ No If Yes, Give Year or Dates: ¶47-68 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2K Married 1 ☐ Yes 2 📉 No Specify Specify: White timore/ MarViand 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 7 Is marked other than "nature traumatic event, the Wedical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ education high school teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fill and Mental H Hermann Franz Bienes Katharina Rusch ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4125 Webster Road Havre de Grace, MD Erna Bienes/spouse other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ᇴ Department of Important: If it any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Sign ture Funeral Service Ronal State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** codiac /Medical Due to (or as a consequence of): Examiner oronach Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of Attending Physician: The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≦ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy pertension 1 ☐ Yes 2 No 25. Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 30. Name and address of person who

MAR 0 3 2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month 7:08 am February 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Forest HAVEN NUrsing Home Catonsville timore 8. Date of Birth (Month, Day, Year) Jan 31, 19 Year If Under 24 Hrs. last birthday) If Under 1 Birthplace (State or Foreign Country) Social Security Number Days Months 1 ▼ M 2 □ F 1929 80 Virginia 230-32-9611 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2√ No Baltimore Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1801 Wentworth Road 21234 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Mack/daughter 3300 Taylor Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4□Donation 5♥Other(Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Servi Director Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASC Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? nditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me

Physician

/Medical

Examiner

10a. State

Director

Completed by Funeral

Be

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Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Box 68760.

or Vital Records, P.O.

Division

To the Hospital or Attending

The law requires that the death certificate be executed

Examiner

Physician/Medical

Completed by

Be

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Certification:

Medical

attending physician and for use as the burial-tran page 2 certificate this After within 24 hours after veca...

To the Funeral Director; After a principle of the funeral principle of the fur

that initiated events resulting in death) Last
IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown
Part II. Other significant co

Dal

	1 ☐ Yes 2 ☐	No 3□P	robably 4 ⊟Unkno	wc
	24a. Was an autopsy performed2 1□ Yes 2 ☑ No	prior to death?	utopsy findings availa completion of cause s 2 □ No	abl of
26. Place of Death	(Check only one)			

١	
	25. Was case referred to medical examiner?
l	1 Yes 2 No

Hospital: 1 Inpatient 2 🗆 E 28a. Date of Injury (Month, Day

H/Outpatient	3 🗀 L	JUA	
28b. Time of Injury		28c.	Injury at Work?
	B.4		1 🗆 V 🚥

Other:

4 Nursing Hom	e 5 ∐ Residence	6 ∐Other (Specify)
y at 28 k?	d. Describe how in	jury occurred

27.	Manner of Death	
	1 Natural	5 🗌
	2 Accident	
	3 ☐ Suicide	6 🗌

4 Homicide

Pending investigation 6 ☐ Could not be

			M		1
y - At home,	farm,	street,	facto	ry,	offic

	28d. Describe now injury occurred
□No	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)

L		
1	29a. Certifier	
1	(Check o	
- 1	1	

28e. Place of injur building, etc. 1 Certifying Physician: To the best of my knowledge, death occur 2 Medical Examiner: On the basis of examination and/or investigation.

and manner stated.

red at the time, date and place	e, and due to the cause(s) and manner as stated.	
tion, in my opinion, death occi	urred at the time, date and place, and due to the cause	(s)

29b. Signature and title of certifier	
29b. Signature and title of certifier Af "A Cuesed"	MD
0	

29c. License number

29d. Date signed	(Month, D	ay, Year)
2/71	1/-	1
4100	7/1	9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AHMEI 821 N'

State Registra

31. Date filed (Month, Day, Year) MAR 03 2009



			1 - For State Registrar	State of I	Maryland /		artment of H tificate of L		and Mental Hy	giene Reg. No. 0)9	062	81		
	Physici	an	1. Decedent's Name (First, Middle	, Last)					2. Date of De Month	Day	Yeer	3. Time of			
Physician Medical Harry Edward Bittinger							FEbruary 19 2009 8:15						РМ		
	Examir	ner	4a. Facility Name (If not institution, Frostburg Nurs:	ing Center							y of Death Bany				
**	Funeral Director		5. Social Security Number 214–12–3385	6. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under: Hours	Min. 8. Date of Bir (Month, Dir Oct 31	th ay, Year) , 1915	9. Birthi Cour Mar	place (State of http:/ yland	r Foreign		
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Lo	cation					Od. Inside Ci	ty Limits		
	Many -f sho	ţō	MD Alleg	anv	Fre	stb	iro					1 🗆 Yes	2∏No		
	r 28a	irec	10e. Street and Number	any	110	2360	10f. Zip Code			10g. Citizen of	What Cou	ntry?			
	th with	aiD	l Kaylor Circl	е			2	1532		USA	A.				
336	init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland criment of Health and Mental Hyglene. ortant: if item 27 is marked other than "natural", or items 23a or 28a-f show hipry or other traumatic event, the Medical Examinar must be notified at all 1888.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marri 3 双 Widowed 4 □ Divorced	12. Was Decede Armed Force ed 1 Tes 2 If Yes, Give Year or Date	es? X∑No		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2X No		gin? (Specify Yes or No , Puerto Rican, etc.)	Bla	ce America ck, White, fy: whi	etc.			
9-0	2 hou	ted	15. Decedent		168	a. Deced	lent's Usual Occupa	ation	a of wadena	16b. Kind of B	lusiness/In	dustry			
21215-0036	thin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	kind of work done a DO NOT use retired,))	or working						
21	filed within Hygiene. Ither than "	ပ္ပ	7	0		ha	ndyman	40 14-45-	de blance (Piers baidette	i	ious				
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Mes	To Be	17. Father's Name (First, Middle, I Edward Bitting						r's Name <i>(First, Middle</i> Ssie Victor						
	and 2 sho ealth and I n 27 is ma	ľ	19a. Informant's Name/Relationsh Mary Holmes/dau						or or Rural Route Numb costburg, M		_	Code)			
Baltimore,	permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other trau once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☼ Donation 5 ☐ Other (Se		comet	of Dispo	sition (Name of natory or other place	8)	Date	20c. Location	- City or To	own, State			
Balt	pernit. Page Department of Important: If any injury or once.		21. Signature of Europeal Service Ronald	kensee Wade, Da	region				oard 655 W.	baltim	ore S	treet			
			23 . Part1. Exter the disease, or shock, or eart failure. List	omplications that cau	sed the death. Do	not ent	ltimore, er the mode of dying	g, such as	cardiac or respiratory a	rrest.		Approximate Interval Beh	e ween		
	Physician /Medical Examiner		Immediate Cause (Final disease or condition									Onset and I	Death		
			resulting in death)	Due to (or	as a consequence	of):	ardial	1	COOCION						
	Lxanime		Sequentially list conditions,	b. Due to fee	2000 na	14	allery	aus	res						
	pet nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	509 15 (6)	as a consequence	970	F.C.								
oʻ	sate be executed obysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or	as a consequence	e of):					_				
8760,	hysicithe bu	dica		d											
9 x	ding p	/Me	IF FEMALE:	23c. If yes, outcome	me of pregnancy					004.0		-46			
.O. Box	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth	n 2 Fetal deat t at time of death		Ectopic pregnancy Other (specify)				ate of delive onth	•	/ear		
ď.	res that igned b	by Pi	Part II. Other significant condition	ns contributing to deat	h but not resulting	in the u	nderlying cause give	n in Part I.	23e. Did	obacco use con	tribute to the	he cause of d	eath?		
rds	w require been sig should b								1 🗆	Yes 2□No	3 🗌 Prot	bably 4 10	Inknown		
Records,	0 5 5	ompiet	Completed	ompiete							24a. Was auto perfe 1 □ Yes	psy ormed?	Were auto prior to co death? 1 Yes	psy findings ampletion of ca	available ause of
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					26. Place	of Death Check only						
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on C	After fune	lon	27. Manner of Death 1 SNatural 5 ☐ Pending		Day Year) 28b.	Time of Injury	Work	(?		how injury occur	red				
Division	r Attending er death. rector: After by the fune	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determi	ot be 28e. Place of	Injury - At home, etc. (Specify)	farm, str		Yes 2⊡!		Street and Numi wn, State)	ber or Rura	al Route Num	ber.		
0	pital or ours afte eral Dir filled in		29a. Certifier 111 Certifyin			a doot	and at the time	o data an	d place, and due to the	anuna(a) and m		totad			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical I one)	Examiner: On the basi and manner	s of examination a	ind/or in	estigation, in my op	pinion, dear	th occurred at the time,	due to the cause(s) and manner as stated. t the time, date and place, and due to the cause(s)					
	With To Corr	×	29b. Signature and title of certifier	Heim			29c. License			PEBRUM		-	ì		
			30. Name and address of person Harjit S Sid				Print) Center F	rosth		502					
	Sta		31. Date filed (Month, Day, Year)	32.009	istrar's Signatur	A	wed .								
100	Regist	rall	NAR 03	2003 1000	, of	7									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 7 per Th 8890 4-2-09 vt

State of Maryland Department of Health and Mental Hygiene
amend #21&22 Per ANA BD G889 3/03/09 Jn

Certificate of Death

Reg. No. 200 For State Registrar Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** P^{M} 2009 23, 1:40 Arlie **Breedlove** February /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Garrett Oakland Nursing & Rehab Center 0akland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye July 12, Birthplace (State or Foreign Country) **Funeral** Year) Min. Months Days Hours 1 X M 2 □ F 85 West Virginia 1923 Director 216-18-1131 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10h. County 10c. City. Town or Location 28a-f show ral", or items 23a or 28a-f shov 1 ☐ Yes 2√ No **Funeral Director** MD 0akland Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with it and of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or uny or other traumatic event, Irm Modical Exc., increment bury 706 Alder Street 21550 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. Specify: white Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clyde Breedlove Pearl Hinebaugh ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy Corby/niece 1373 Silver Knob Road Oakland, MD 21550 20b. Place of Disposition (Name of cametery, crematory or other place, 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages Department of Important: If it any Injury or o 22. Name and Address of Facility State Anatomy Board 655 Balto.ST 21. Signature of Funeral Service Licensee Donald S. Wade, Director

Record per DVR

David A. Burdock Funeral I 21 N. Second St., Oakland,

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. David A. Burdock Funeral Home, 21 N. Second St., Oakland, MD 50 Balto MD01 Approximate Interval Between Onset and Death Immediate Cause (Final week **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) Physician/Medical Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2000 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation neral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 24 hor **To the Fune** completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier urz 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MELGARE 32. R Year) 31. Date filed (Month, Day, State MAR 03 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 4b per MD g889 3/3/09 TT Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2009 **Physician** 4:55 A.M THEODORE JOSEPH BANASZEWSKI FEB. 23. /Medical 4c. County of Death Facility Name (If not justitution, give street and number) 4b. City, Town, or Location of Death **Examiner** CARROLL MANCHESTER 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Min 1√2 M 2□ F 214-03-7482 90 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27/s marked other than "natural"; or items 23a or 28a-f show any injury or other fraumatic event, the Mudical Experimental Progressions once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 □Yes 2 XNo Director CARROLL HAMPSTEAD MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1148 GYPSUM DRIVE 21074 UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 □Yes 2X No WHITE Specify. Specify: þ 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 6TH College (1-4or 5+) PRESS FEEDER AMERICAN CAN CO. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANDREW BANASZEWSKI ANN ROZANSKI ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) ROBERT BANASZEWSKI/SON 1148 GYPSUM DR., HAMPSTEAD, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2/27/09 OAK LAWN CEMETERY BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Enter the disease, shock, or heart failure is only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MAON **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to Innie list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a conse wence of Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 ☐No g Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 deatn? 1 □Yes 2 🕅 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: [°] 2**X**No To the Hospina. Suithin 24 hours after death.

To the Funeral Director. After this committeely filled in by the funeral director. 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □ Other (Specify) 1 Tes 1 Inpatient Medical Certification: To this 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 0051705 UM STURNED

Registrar

State

DR, Westminster, MD 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PANSURIY

31. Date filed (Month, Day,

349 malculm

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 9:30 P M FEB. 28,2009 JOHN BRYNES 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) TOWSON BALTIMORE GILCHRIST HOSPICE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Sex 1 M 2 □ F Days Hours 43 NOV. 4,1965 MD 219-78-6708 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 □Yes 2 □ No MD BALTIMORE COLGATE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7604 GOUGH ST 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2X No WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) NONE College (1-4or 5+) NEVER WORKED N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY LANCASTER JOHN BRYNES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) COLGATE, MD 21224 7604 GOUGH ST ANGEL MARTIN-SISTER 20c. Location - City or Town, State Date Un K 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ATLANTIC CREMATORY GLEN BURNIE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee CHARLES S. ZEILER & SON, INC 6224 EASTERN AVE BALTIMORE, MD 21224 are, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest list only one cause on each line. 23a. Part-1. Enter the dise shock, or heart failur Onset and Death Immediate Cause (Final disease or condition resulting in death) wecks Spiran Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): fetard Due to (or as a consequence of): yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2. No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performe 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOS OUL Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28d. Describe how injury occurred

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any Injury or other traumatic event, the Medical Exponse.

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural"

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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The law requires that the death certificate be executed has

Records, P.O. Box 68760.

Hospital or Attending Physician:

Examiner Physician/Medical δ Completed Be Medical Certification: To After this after death To the Hospital within 24 hours a To the Funeral Completely filled

25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No

4 Homicide

29a. Certifier

1 Natural 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide

determined

28a. Date of Injury (Month, Day, Year)

Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

MAR 0 3 2009

29c. License number

29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

Charles 31. Date filed (Month, Day, Year) 2. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Bernice Audelle Beard February 22, 2009 p^{M} 2:55 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George Shanti's Place Assisted Living Laurel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Days Months Hours 1 M 2/CKF 88 Yrs. 579-12-1462 Director Nov. 6, 1920 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show in items 23a or 28a-f shoring at 1 ☐ Yes 2XXNo Director MD Prince George Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13000 Golden Oak Drive 20708 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐Yes 2 No Specify Specify: white Health and Mental Hygiene. em 27 Is marked other than "natural", or ther traumatic event, I'm Medical Eval. ξ. 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maurice McClanahan Florence Hutchinson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any Injury or other troone. Bonnie L. Beard/ Daughter 13000 Golden Oak Drive, Laurel, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 25 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) West Arundel Crematory 2009 Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee J. Key Stels 313 Talbott Ave., Laurel, MD_20707 M01053 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Hypertensive Cardiovascular Disease many years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physlcian: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician s the burial P.O. Box 68760, Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) 1 ☐Yes 2X No signed by the a 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Anemia, Depression Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 sl autonsy performed' 1 ☐ Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Group Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)Home 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1XXNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death

Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral DI

completely filled in Medical 29a. Certifier 1/LIXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Do is out 1 is D23181 February 24, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R.G. Bhojraj, MD,704 Gorman Ave., #T-1, Laurel, MD 20707 32. Registrar's Sigulature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	1 - State of Maryland / Dep State Registrar Ce	artment of Health a rtificate of Death		ne 2009	06286			
I	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death				
	/Medic	al	Ella Mae Barton 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location		27, 2009 4c. County of Death	10:20 P.M			
	Examin	er	1311 W. 42nd Street	Baltimore		N/A				
	Funeral Director		5. Social Security Number 217–18–0933 6. Sex 1 M XXF 7. Age (In yrs. last birthday, 88 Yrs.	If Under 1 Year If Under Months Days Hours	Min (Month Day Ye	9. Birth 1920 Mary	place (State or Foreign ntry) 1land			
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Literature	ocation			10d. Inside City Limits			
	a-f sh	ctor	Maryland N/A Baltimo:	ce			Yes 2□No			
	vith the	Director	10e. Street and Number 1311 W. 42nd Street	10f. Zip Code	10g.	. Citizen of What Cou	ntry?			
	eath v	Funeral	11 Marital Status 12, Was Decedent Ever in U.S. 13.	21211 Was Decedent of Hispanic Orl If Yes, specify Cuban, Mexicar	igin? (Specify Yes or No-	USA 14. Race - Ameri	can Indian,			
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. Predicts Exact fract must be recitifed at Once.	by	1 News Married 2 Married 1 Ves 2 1 No	If Yes, specify Cuban, Mexicar 1 □ Yes 2 No Specify:		Black, White, Specify: Wh	etc. nite			
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nd	tal Hyg d othe	Be	17. Father's Name (First, Middle, Last) Thomas Sullivan		er's Name (First, Middle, Mai a Mae Fouch	den Surname)				
<u> </u>	hould I d Men marke matic	မ	·	ng Address (Street and Numb	·	lity or Town State Zi	n Code)			
Ma	nd 2 sl alth an 27 is 1		, , , , ,	237 Sebring Dr			•			
Baltimore, Maryland 21215-0036	Pages 1 a nent of He ant: If item ury or othe		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition 2 Democratic from State	osition (Name of matory or other place)	Date 20d	C. Location - City or To Ownsville,	own, State			
Baltii	permit. P Departm Importar any Injur			2. Name and Address of Facili Burgee—Henss—Se 1631 Falls Road						
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	/Medical Examiner		resulting in death) Due to (r as a consequence of):	me deces		jears				
	- 67 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ny made		4-00-03				
	ecuted and x	Examiner	that initiated events c.							
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Division of Vital Records,	: The law ricate has be page 2 sh	Completed			24a. Was an autopsy performer	prior to co	opsy findings available ompletion of cause of 2 No			
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اه ر	ding Phy h. After this funeral d	n:Te	27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe how					
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ΟĬΧΪ	tal or At rs after d al Direct ed in by	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal can be dealered and manner stated. Certifying Physician: To the best of my knowledge, dealered and manner stated.							
	To the within To the comple	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month,				
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-	9		200 Co. Ant 33 24 AT Mol.	to well :	21218					
	Sta		30. Name and address of erson who completed cause of death (Item 23a) (Type 2 of 3 3 in 1997) (Type 3 of 3 o	barre						
	Registr	ar	WAR 0 3 2009 Elever P. 2	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene U 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Mary Louise Brown February 28, 2009 5:37 P 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Center 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex 1□M 2ਊF Months Days Hours Min. Jan 30, 1924 85 219-18-9359 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 ☐ Yes 2 No Maryland Parkville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 8820 Walther Blvd., apt. 4026 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🔯 No Specify White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert Adams Mary Vane 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Cypress Road, Portsmouth, Anita L. Carty/Daughter VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 3/2/09 22. Name and Address of Facility.
Lemmon Funeral Home of Dulaney Valley Inc. Bryan W. Clary 10 W. Padonia Road, Timonium, Maryland 21093 23a. Part 1. Emer the usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart fillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat - Cause (Fire I disease or condition resulting in Neath) Kisterphagic Due to (or as a consequence of) pertensin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Liecaes of injury that initiated events resulting in death) Last Due to (or 1/2 consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknow art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 □ Yes 2 1 ☐ Yes 5. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence (Specify) NUSPILE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner Division of Vital Records, P.O. Box 68760,

requires that the death certificate be execute ō Hospital

an/Medical Examiner attending physician and for use as the burial-tra funeral director, Medical Certifical

Physician

Examiner

Funeral

Director

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Medical Ever in the institute to confidence.

Physician /Medical

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Baltimore, Maryland 21215-0036

2/38/2009 1

/Medical

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29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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Registrar

7. Manner of Deat Natural 5 Pending investigation 2 Accident

3 Suicide 4 Homicide

6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

N-Charles

29d. Date signed (Month, Day, Year) 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

in

32. Registrar's Signature

		For State	State of	f Marylan	-	artment of F		and Mental	Hygie	0000	052	28	
		Registrar 1. Decedent's Name (First, Middle	e, Last)			- Inouto or I			of Death	2000	3. Time of	Death	
Physicia		Betty Lou	Bea1	1				Febr	uary	27, 200		РМ	
/Medic Examin	_	4a. Facility Name (If not institution				4b. City, Town, or	Location (of Death		4c. County of De	ath		
		15029 Jarrettsv				Monkt				Balti			
Funeral Director		5. Social Security Number 213-44-8372	6. Sex 1 ☐ M 2 🂢 F	7. Age (In yrs. 73	last birthday) Yrs.	If Under 1 Year Months Days	Hours	Min. 8. Date (Monitor) May	of Birth th, Day, Ye		irthplace <i>(State</i> o Co <i>untry)</i> aryland	r Foreign	
pur w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside Cit	ty Limits	
Aaryle f sho	0		•								1 □ Yes	2 ∑ No	
the 7	Director	Maryland Balt 10e. Street and Number	imore		Monk	10f. Zip Code			10g.	Citizen of What C	Country?		
3a ol	5									US.	A		
deatl	Funeral	11. Marital Status		dent Ever in U.	S. 13. \	Was Decedent of H			or No-	14. Race - An Black, Wh			
after or ite	by Fu	1 ☐ Never Married 2 📈 Marr	ied 1 □Yes If Yes, Giv	2 Mo ∕e		1 □Yes 2 ☑ No	Specify:		,	Specify:			
72 hours after death with the Maryland natural", or items 23a or 28a-f show dien Examiner must be notified at		3 ☐ Widowed 4 ☐ Divorced	Year or Da	ates:	16a Dece	dent's Usual Occup	ation		16h	White Kind of Business/Industry			
in 72 n "nai	Completed	(Specify only highes	st grade completed)	45->	(Give	kind of work done of NOT use retired	durina mos	t of working	100	. rand or basines	and of Eddinosoffication y		
y with giene	E	Elementary/Secondary (0-12)	College (1 n/			Homemakeı	c			Own Home			
al Hyg	Be C	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name (First, M	liddle, Maid	den Surname)			
ould b Ment Markec	ဥ	Benjamin C		khan				uth Ev		Hannib			
2 sh h and is m raum		19a. Informant's Name/Relations				ng Address (Street						1111	
1 and Healt em 2		Earl N. Beall,	Sr./Husba			9 Jarrett sition (Name of natory or other place		Le Pike,		Location - City of		1111	
ages ent of rt: If it y or o		1 ☐ Burial 2 ☑ Cremation 4 ☐ Dopation 5 ☐ Other (S	3 Removal from	State		hatory or other plac Cremator	i .	/2/09	G1	en Burni	o Marvi	and	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantiner must be notified at once.		21. Signatur of Funeial Service		TALI	22	Name and Addreemmon Fur 0 W. Pado	ss of Facilit	tv			-		
402 # G		23a Part 1 Enter the disease or	complications that o	aused the deat	h Do not ent	O W. Pado er the mode of dvir	onia]	Road, Tin	noniur	n, Maryl	Approximate	е	
Physician		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on e	ROODY	utory	Farlur	2				Onserval Bet	ween	
/Medical Examiner		resulting in death)	Due to	or as a consequence	uence of):	Failur a Gar	NO				year	Ó	
led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a consequ	uence of):								
sxecut and al-tran	xan	that initiated events resulting in death) Last	c	or as a conseq	uence of):								
cate be executed physician and the burial-transit	dical		d										
ertific ling p	Med	IF FEMALE:								T			
Attending Physician: The law requires that the death certific refeath. scroor: After this certificate has been signed by the attending put the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 Live I	come of pregna pirth 2 Feta nant at time of c	ıl death 3 □	Ectopic pregnand Other (specify)	ry		-	23d. Date of c			
at the d by the etach	Phy	9 Unknown			ulting in the u	ndorlying cause giv	on in Part 1	23e	Did tobac	co use contribute	to the cause of d	leath?	
The law requires that the decate has been signed by the page 2 should be detached	ed by	Dialeteo							1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unkn				
aw reas bec	Completed	Chunu	Benow 1	-aveu	<i>v</i> .			24a.	Was an autopsy	24b, Were	24b. Were autopsy findings available prior to completion of cause of		
The late has page	E O							10	performed Yes 2 🔀	i? death'		2000 01	
ician: Th certificate ector, pag	25. Was case referred to medical examiner?												
hysi this c	Popital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									pecify)			
ding I h. After funer	ertification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin investig	9 1	th, Day, Year)	28b. Time of Injury	Wor	ryaτ k? Yes 2□		cribe now i	njury occurred			
Atten deat ctor: by the	fica	3 Suicide 6 Could	not be 28e. Place	of Injury - At he	Į ome, farm, str	eet, factory, office		28f. Loca		t and Number or	Rural Route Num	ber,	
ital or virs after ral Dire	Certi	4 nomicide	bulla	ng, etc. (Specif	····				City or Town, State)				
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1	Examiner: On the b	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my o	me, date a opinion, dea	nd place, and due ath occurred at the	to the caus time, date	se(s) and manner as stated. e and place, and due to the cause(s)			
To th within	ž	29b. Signature and title of certifie	amo 1	W		29c. Licens	e number	3245	3 29d.	Date signed (Mo.			
6		30. Name and address of person	who completed caus	se of death (Iten	n 23a) (Type,	Print)							
		Mark Lamos, M.	D. 9 Sch	illing	Road,	Hunt Val	ley, l	Maryland	2103	30			
Sta Registr		31. Date filed (Month, Day, Year)	2009 3	egistrar's Signa	so so	de							
NEGISUI		MAR U3	MA KAN	and p	d								

09-01634 Major Bailey		Please Type Stat	or Print in B e of Maryland	lack Ind / Depart	elible Ir	i k. Ensu Health a	re All Cop nd Mental	oles Are Leg Hygiene	gible.	
		- For State	o or many tame	Certi	ficate of	Death			eg. No.	00 000
Physicia	an/	1. Decedent's Name (First, Middle, I	ast)				1988	2. Date of Deat Month February 2	Day Year	0200 hrs
Medical Examin		Major Bailey, Jr. 4a. Facility Name (if not institution,	give street and number)	4	b. City, Town,	or Location of De		4c. County of Deat	h ,.
(Maryland General Hosp	ital			Baltimore				
uneral	- 1			ge (In yrs. last	t birthday)	If Under 1 Y		Min	th(MM/DD/YYYY) 9. Bi	rthplace (State or gn puntry) VA
Director	L	212-36-1092 1	X M 2 F	69	Yrs.			07-09-1	.939	VA
any		10a. State 10b. County		10c. City, To	own or Locati	on				10d. Inside City Limits 1 X Yes 2 No
: land f show	ē	MD N/A		Balti	more	101 7:- 0-4-			0g. Citizen of What Cor	
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number				10f. Zip Code				
vith the	a D E	503 Violet Ave Apt (12. Was Deceder		. 13. Wa	212: s Decedent of	Hispanic Origin?	(Specify Yes or No		ncan Indian, Black,
death v r item nust b	Funeral	1 Never Married 2 Marr	ried Armed Forces	s? 2 X No	- 1		oan, Mexican, Pu	erto Rican, etc.)	White, etc.	
s after ral", o	J.	3 X Widowed 4 Divor 15. Decedent's Education (Specif	or Dates:	mploted)		Yes 2 X	No specify: pation (Give kind	of work done	Specify: ATT1	can American
2 hour "natu	eted	Elementary/Secondary (0-12)	College (1-4 or	/			life. DO NOT use		11	
036 rithin 7 rithin 7 rithan rithan rithan	Completed	9th			Rat Rat	<u>ificatio</u>		(-1)	Baltimore Ci	ty
filed w Hygie d othe	O e	17. Father's Name (First, Middle, L Major Bailey, St					18.Mother's N	ame (First, Middle, loward	Maiden Surname)	2
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depantement of Health and Mental Hygiers in 172 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other trainmatic event, the Medical Examiner must be notified at once.	To Be	19a. Informant's Name/Relationshi		 	19b. Mailin	Address (St	_		mber, City or Town, Sta	te, Zip Code)
MD d 2 sho lth and n 27 is		Agnes Howard/Mother	<u> </u>	T				S. Baltimo	ore, MD 21215	or Town State
ore, es 1 an of Hea If iter		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from S	State cr	ematory or ot		1	2-27-2009	Baltimore, N	
timent retaint:		4 Donation 5 Other Spe 24 Signature of Funeral Service L	cify:	Metr	o Crema	-			al Home P.A.	ш
Bal permi Depar Impo injur		albut Public			638	N. Gilm	or Street	Baltimore.	MD 21217	
Physician		23a. Part I. Enter the disease, or c failure. List only one cause o	n each line.		Do not enter t	he mode of dyi	ng, such as cardi	ac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	a. Chronic Obstru			sease with	Complication	ns		Death
1		Sequentially list conditions,	b.	isequence or/	•					
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	nsequence of)	:		112			
d sit	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence of)	t .					5-7
executed an and al - transi	g	UNPENDED	d							+
60, ite be e hysicia e buria	Medi	IF FEMALE:	23c. If yes, outo	come of pregn	ancy				23d. Date of deliv	ery
n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be excouted h. A. After this certificate has been signed by the attending physician and enumeral director, page 2 should be detached for use as the burial - transit	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 F	etal death	3 Ectopic pr	egnancy	Month	Day Year
Sox death c e atten	ysic	1 Yes 2 No 9 Unkr	7		5 O	ther (Specify)				
s, P.O. Bc nires that the des signed by the a		Part II. Other significant condition				underlying cau	ise given in Part I	23e. Did	tobacco use contribute es 2 No 3 P	to the cause of death? robably 4 V Unknown
S, P puires th	ed by	Hypertensive Atheros	clerotic Cardiovas	cular Dise	ase					autopsy findings available
cord law req has bee 2 shou	ompleted					·		auto	opsy prior to formed? death	
Division of Vital Records, tal or Attending Physician: The law require as after death. Director: After this certificate has been siled in by the fineral director, page 2 should b	S	25. Was case referred to medical				26.F	Place of Death (CI	1 Yes	2 No 1	Yes 2 No
/ital ysician his cert	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa	atient 2	ER/Outpatier	t 3 DOA	Other ₄	lursing Home 5	Residence 6 Ot	her:
n of V ding Ph. After tl funeral	Ë	27. Manner of Death	28a. Date of I (Month, Da	njury y,Year)	28b. Time of	· · · .	Injury at Work?		e how injury occurred	
Sion Attend death.	Certification:	Pendi	tigation	f tojuny - At ho	me farm str		Yes 2 N		(Street and Number or	Rural Route Number, City
Division pinal or Attent ours after death teral Director: filled in by the	artifi		not be 28e. Place of mined (Specify)	i filjuly - Actio	ino, idini, ou	501, 140101, 9, 011	Jamanig, coo	or Town,		
Hospi 24 hou Funer		29a. Certifier 1 Certifying Ph	ysician: To the best of	f my knowledg	ge, death occ	urred at the tim	e, date and place	e, and due to the ca	use(s) and manner as s	tated.
Division To the Hospital or Attend within 24 hours after death within Functed Director completely filled in by the	Medical	one) 2 Medical Exam	and manner state	examination ar ed.	nd/or investig		inion, death occu cense number	rred at the time, dat	e and place, and due to	
3	Σ	29b. Signature and title of certifier	li'			1	.C.M.E.	O GME	February 26, 2	
		3. Name and address of person	who completed cause of	of death (Item	23a)					
		Theodore M. King, Jr.,	MD. Assistant	Medical E	xaminer		Street, Balti	more, MD 212	01	
S Positi	tate	31. Date filed (Month, Day, Year)	009 37 Regis	strar's Signat	· pa	Ked				

State of Maryland / Department of Health and Mental Hygiene 09 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 8:03 AM 02 200 Laura Faulkner Byrd /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗶 F 217-58-5845 44 September 30 1964 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is deather than any injury or other traumatic event, it is deather. 1 ☐ Yes 2 No Director Maryland Baltimore Lutherville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 200 W. Seminary Avenue 21093 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2K Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 2 White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 <u>Project Manager</u> Graphic Design 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Edward Byrd, III Laura Mae Faulkner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Jeffrey Head / Husband 200 W. Seminary Ave., Lutherville, MD 21093 altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Corp. 03-03-2009 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) neral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Sign Ture 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician AOKTIC disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 ∏Yes 2 XNo certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🖾 No To the Hospital or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 🛮 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4389 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANNERY MEMORIAL TOSPITAL BALTIMORE MD 21218

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Raistrar's Signature

09-01588 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Anthony Battle State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle Last) 2. Date of Death Month Day February 23, 2009 1400 hrs Medical Examiner Battle Anthony Done11 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Prince Georges Hospital Cheverly 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) **Funeral** Foreign Months Days Hours Min Director 80 റമ 66 Country) TX 42 551-39-7113 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Yes 2 X No 28a-f show Upper Marlboro once. MD Prince Georges Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12830 Carousel Court 20772 U.S.A. Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc Never Married Married 1X Yes If Yes, Give Year Black Widowed 4 X Divorced Yes 2X No specify: Specify: ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Friendship Public Elementary/Secondary (0-12) College (1-4 or 5+) 72 27 is marked other than ' Baltimore, MD 21215-0036 Pages 1 and 2 should be filed within ient of Health and Mental Hygiene Human Resource Manager 12th grade 3yrs Charter Schools 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be | Cheryl FULDIII

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

772

1000 Marlboro, Md Anthony Wilson 19a. Informant's Name/Relationship (Type, Print) Johnathan Battle-Son Important; If item 27 injury or other traums 20a. Method of Disposition Date 20c, Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation cremoorkor other dace) Removal from State Doris **Willer** Memorial 3/7/09 Waco, Texas Donation 5 Other Specify Sig ture of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, 21215 Part I. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death a Cardiac arrhythmia associated with physical Immediate Cause (Final disease **J**aminer or condition resulting in death) Due to (or as a consequence of): altercation Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical 23a,27,28a-f,perME Item#20b,perFH,G889 attending physician or use as the burial -X UNPENDED X AMENDED Box 68760. IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Year Day 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown detached P.O. 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. 9 Yes 2 No 3 Probably 4 V Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page certificate Yes 2 1 V Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other: 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 Other this Inpatient ပ 1 V Yes 2 No After 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: subject in altercation Yes 2 X No e Funeral Director: A letely filled in by the fu Natural Pending 2/23/09 Fd 1:15 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12830 Carousel Ct 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide residence determined Jpper Marlboro, Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

Hospital or Attending Physician:

State

DHMH 17 Rev 1/2001

OCME 2006

Registra

ORIGINAL

2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 24, 2009

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Donna M. Vincenti, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death EMPHUARYDAYES, EYEARIS Bailey M. Lula 4b. City, Town, or Location of Death 4c. County pf Peath imore 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center Year) 34 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 03 24 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Days 1 □ M 2 🔀 F o3 213**-**32**-**5386 74 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Kes 2 No Baltimore NA 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21216 2516 Arunah Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ☐ Widowed 4 ▼ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) Office Disability 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) lementary/Secondary (0-12) Social Security Adm. Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillie Mae Boyd Darist McQuaige 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 2029 Woodlawn Drive, Apt A, Baltimore, Md 21207 19a. Informant's Name/Relationship (Type. Print) Andrea Rawles-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/6/09 Arbutus, Md Arbutus Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H west 21215 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4300 Wabash Ave, Baltimore, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIOGENIC SHOCK Due to (or as a consequence of): ACUTE MYOCARDIAL INFARCTION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery Dav use contribute to the cause of death? 3 Probably 4 Unknown No. 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ital Madical Evanitar must be notified at agree.

Saltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

Be

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MD

b Hospital or Attending Physiclan: The law requires that the death certificate be executed 24 hours after death.
Pruneral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical Be Completed by Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 W No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Yea
Part II. Other significant conditions	contributing to death but not resulting in	the underlying cause given in Part 1.	23e. Did tobacco use contribute to the cause of deat 1 □ Yes 2 No 3 □ Probably 4 □ Unk
			24a. Was an autopsy performed? 1 □Yes 2 4 No 1 □Yes 2 □No
25. Was case referred to medical		26. Place of D	eath (Check onl. one)
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Out	patient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigati		ime of Jac. Injury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		m, street, factory, office	28f. Location (Street and Number or Rural Route Number City or Town, State)
29a. Certifier Certifying F	hysician: To the best of my knowledge	, death occurred at the time, date and pla	ace, and due to the cause(s) and manner as stated.

State Registrar

Medical

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DRIVE TOWSON MARYLAND 21204 OSLER 7621 Registrar's Signatu

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the I within 2

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 30263

29d. Date signed (Month, Day, Year)

			For State	State of Marylan	-	artment of F			giene	9 06293
P	70		Registrar 1. Decedent's Name (First, Middle, Last	')				2. Date of Dea		3. Time of Death
	Physicia		MARTIN RICHARD	CLARKE				Februar	y = 28, 200	09 6:00A M
	/Medic Examin		4a. Facility Name (If not institution, give				r Location of Death		4c. County of	Death
	(1)		1111 Overbrook Road			Baltim			Balti	
	Funeral Director			7. Age (In yrs. 68	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 1	, 1940 N	n. Birthplace (State or Foreign Country) Naryland
	and www.		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Maryl -f sho	tor	Maryland Baltimor	e l	Baltimo	ore				1 □Yes 🏋 No
	h the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	23a c ust be	ral	1111 Overbrook Roa			2123			USA	
936	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Inpartment of Health and Mentall Hygiene. Important: If item 27 Is marked other than "natural" or tems 23a or 28a-f show Important: If item 27 Is marked other than "natural" or temperatural or the most be notified at one. In jury or other traumatic event, the Medical Examiner must be notified at one.	by Funeral Director	11. Marital Status 1 □ Never Married XX Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes XX No	lispantc Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
ည်	72 hor	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	I (Give	dent's Usual Occup	during most of work	king	16b. Kind of Busin	ness/Industry
2	/ithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)wner	d)		Taverr	า
, D	filed w Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)	T		JWITCI	18. Mother's Nam	e (First, Middle,	Maiden Surname)	
Maryland 21215-0036	Mental Mental arked o atic eve	To Be	Harry Martin Clark					Zeller		
Mar	and 2 sho alth and 27 Is m er traum		19a. Informant's Name/Relationship (To	ype. Print) Wife	1		and Number or Rui ok Road E			
Baltimore,	of He of He if item		20a. Method of Disposition 1 ☐ Burial 2 🕅 🛣 emation 3 ☐ I	Bemoval from State	cemetery, crei	osition (Name of matory or other plac	ce)	Date	20c. Location - Ci	
Ë	: Pag tment tant:		4 □ Donation 5 □ Other (Specify,) Gree		t Cremato	•			e, Maryland
Ba	permit Depar Impor any In		21/Signature of Funeral Service Licens	Menakes	22					JNERAL HOME INC Vland 21212
4			23a. Part1. Enter the dise e, or comp shock, or heart failure. List only				ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Respirator		st				
	/Medical Examiner			Peripheral		lar Disea	SP			
	- 2	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec			-			
D.	od d ansit	Examiner	di any, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events	Coronary A	rtery I	Disease				
Ó,	icate be executed physician and s the burial-transit	Ex	resulting in death) Last	Due to (or as a consec	quence of):					
8760,	ate by	dical		d						
O. Box 6	ath certif attending for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	⊒Ectopicpregnanc ⊒ Other (specify) _	у		23d. Date of Monti	,
s, P.O.	res that the de igned by the a be detached t	y Ph	Part II. Other significant conditions co	ontributing to death but not res	sulting in the u	inderlying cause giv	en in Part I.	23e. Did to		ute to the cause of death?
ord	w require been sig should b	ted t						1 🗆 \	/es 2√(X No 3	Probably 4 Unknown
		Completed						24a. Was autop perfo 1∐ Yes	psy priegrapsy priegra	ere autopsy findings available or to completion of cause of ath? Yes XX No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes XX No	Hospital:		ot 3DDOA Oth	26. Place of Dea			
ö	Phys r this ral di	٦.		28a. Date of Injury	28b. Time o	III JUDOA			dence 6 Other	
on	Attending r death. ector: After by the fune	tion	27. Manner of Death **TXNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? Yes 2∐No			
Visi	er dea rector by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	iome, farm, sti	reet, factory, office		28f. Location (S City or Tox	Street and Number	or Rural Route Number,
Ö	ital or rs afte ral Dir led in	Cert								
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) A Certifying Phyone 2 ☐ Medical Example	ysician: To the best of my kniner: On the basis of examin and manner stated.	owledge, deat ation and/or ir	th occurred at the tinvestigation, in my	me, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and manr date and place, an	ner as stated. Id due to the cause(s)
	To the Comp	Ž	29b. Signature and title of certifier			29c. Licens			29d. Date signed (
			S. Said	ma.		D54	274		March	2, 2009
	10		30. Name and address of person who o	empleded cause of death (Ite Osler Drive			and 21204	1		
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 3 20	32. legistrar's Sign	ature	all				

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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	2:		ite of deli	very Day		Year	
bacc	o us	se con	tribute to	the cau	ise of	death?	
'es	2] No	3 □ Pro	obably	4	Unknow	/n
an sy medi 2 🔲 I			Were au prior to d death? 1 ☐ Yes	topsy fir ompleti	nding: on of	s availab cause of	le

06294

3. Time of Death

8:26 A

MD

10d. Inside City Limits

Approximate Interval Between Onset and Death

1√Yes 2□No

Birthplace (State or Foreign Country)

Reg. No 2009

USA

Specify:

14. Race - American Indian

WHITE

Black, White, etc.

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

3□ DOA 2 ER/Outpatient 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

performed'

2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

impleted cause of death (Item 23a) (Type, Print)

Baltimore MD 21218 3901 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

Completed

Be

Medical

certificate

this

within 24 hours after death

To the Funeral Director;
completely filled in by the

To the Hospital or Attending Physician;

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 2 Certification:

2**N**0 27. Man of Death

2 Accident 3 Suicide 4 ☐ Homicide

determined

6 ☐ Could not be

5 Pending investigation

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM# 7-9perFH, G889, 37, 37, 09, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day 4 Month **Physician** Manuel Leroy Croghan ebruer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balt.-Wash. Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days Hours Months 1 □ M 2 □ F 217-01-6356 Feb.8,1920 Maryland Director Usual Residence of Decedent 10d. Inside City Limits Maryland 10b. County 10c. City, Town or Location 10a State 28a-f show ?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "hadeal Experiment cust be not the as 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena the 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 8539 Bay Rd. 21122 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status after 1 X Yes 2 □ No
If Yes, Give
Year or Dates: WW II 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 XNo Specify Specify: 3 Midowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Foreman Utility iled v Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be find and Mental Pris marked of Be pe Henry Croghan Elizabeth Gross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health al Important: If item 27 is any Injury or other trau once. Erin Sheckells / Daughter 8539 Bay Rd., Pasadena, Maryland 21122 Date 27 3altimore. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 fment of F Feb. 1 EBurial 2 ☐ Cremation 3 ☐ Removal from State 2009 Elkridge, Maryland Meadowridge Mem. Pk. 4 □ Donation 5 □ Other (Specify) 21. Signeture of Fu 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 1-11 3 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or es a consequençe, of) Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy 2 12No 1 ☐Yes 2 12 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 🖪 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this After this funeral o 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 HOSP AND Drive, Ste 3 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Da **Physician** eslie ar ter 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospice DWSON Baitimor If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🗷 F Months Days Hours Min 216-52-836 59 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 ☐ No MD Baltimore **Funeral Director** Baltimore 10g. Citizen of What Country? 10e. Street and Number ō USA ESSEX 21207 3054 items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐Yes 2 ☐No Specify þ Specify: Blac 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Superintendant 12 years and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ucille. claru oSeoh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.9 Department of Health a Important: If item 27 is any Injury or other traugonce. Bette Tanners phareHa,GA 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3-2-09 woodlain, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Breene funeral Sixe 21. Signature of Funeral Service Licensee 728 iberta augh. Rd. Randallstown, Ms 21133 23a. Part 1. Enter tile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear death. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BREAST CANER, WIDELY yeours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, icate has been signicate has been significated by page 2 should by 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy this certificate 1 □Yes 2 DNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) WOSCI & Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: d in by the f 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumler CHALLES 6701 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

2009

ORIGINAL

09-01626 Michelle M. Clary		- For State			l / Depa	artment	Ink. Ensur of Health an o <i>f Death</i>		l Hygiene		
Physician		egistrar I. Decedent's Name (First, M	iddle Last)		- Invocato		, i -	2. Date of De	Reg. No.	B. Time of Death
Medical Examin		Michelle	,	м.		(Clary			Day Year 24, 2009	2300 hrs
		a. Facility Name (if not institute	ution, give				4b. City, Town, or	Location of D		4c. County of De	ath
		Jones Statley Road			,	ad	Arnold			Anne Arund	
Funeral		5. Social Security Number	6. Se:			ast birthday)	If Under 1 Yea	r If Under 2	4Hrs. 8. Date of B	irth (MM/DD/YYYY) 9.	Birthplace (State or Foreign
Director	- 1						Months Day		Min.		Country)
	- 1	219-88-5386		M 2 X F	3	6 Y	rs.		April	11,1972	MD
ż		Usual Residence of Deceder 10a. State 10b. Cou			10c City	Town or Loc	ration				10d. Inside City Limits
w any				0.1	1		oution.				1 X Yes 2 No
and land	٥٤		timo	re City	Bro	oklyn					
Mary 28a	Director	10e. Street and Number					10f. Zip Code			10g. Citizen of What C	ountry?
eath with the Maryland items 23a or 28a-f show ust he notified at once.		911 Annabel A	venu	e			21225			U.S.A.	
ms 2	uneral	I1. Marital Status	1	12. Was Deceder Armed Forces			Vas Decedent of His f Yes, specify Cubar			o- 14. Race - An White, etc	nerican Indian, Black,
deatl or ite	들	1 Never Married 2 X	Married		2X No			i, woxiouri, r	dorto radan, oto.,	Trinte, ott	,
after	و ۲	3 Widowed 4	Divorced	If Yes, Give Year or Dates:		-	Yes 2 X No			Specify: W	<u>hite</u>
nours natur	렸	15. Decedent's Education (Specify on				ent's Usual Occupa most of working life			16b. Kind of Busine	ss/Industry
6	<u>ë</u>	Elementary/Secondary (0-	12)	College (1-4 o	r 5+)		Ÿ		,		a
vithir ene.	Completed			2		Offic	ce Manage		,]	Servcies
5-C		17. Father's Name (First, Mic							Name (First, Middle,		,
The f	a _	Russell Norm							Lee Hard		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiera Maryland Inportant: If it.; 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner, must be notified at once.	- !	19a. Informant's Name/Relat								mber, City or Town, St	
MC dd 2 s lth ar tth ar t 27		Mr Jeffrey B.	Cla	ry/Husbai						sville, MD	
Fitch Can	1	20a. Method of Disposition 1 Burial 2 X Crema	tion 2	Removal from S	- 1		osition (Name of ce other place)		March 3,	20c. Location - City	or Town, State
nt: I		4 Donation 5 Othe		Removal from S	State		c Cremato		2009	Glen Bur	nie.MD
altin mit J sartm	1	21. Signature of Funeral Sec		ee)	1 220					Funeral &	
Dep Dep	-1	U.a.	/	// .	401171	Is	ervices P	A 1 2n	d Ave.SW	Glen Burni	e, MD 21061
Physician		23a. Part I. Enter the disease		ications that cause	AOUZI ed the death						Approximate Interval
/Medical		failure. List only one ca		ch line. Drowni	no						Between Onset and Death
Examiner		Immediate Cause (Final dise or condition resulting in deat		DIOWITE Due to (or as a cor		f):		-			
	-	O	b.	(3, 22, 23, 23, 23, 23, 23, 23, 23, 23, 2		-7-					
	ĕ	Sequentially list conditions, if any, leading to immediate		Due to (or as a cor	sequence o	f):			-		
		cause. Enter Underlying Ca (Disease or injury that initiate	ed C.								
1 1 to 1	Ж Н	events resulting in death) La	131	Due to (or as a cor	isequence o	f):					
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D, be es		X UNPENDED		AMENDED 23	a,PĬĪ	<u>, 27 , 28</u>	90 4/22/0 a-f,perME	, g890	4/23/09	TT	
Division of Vital Records, P.O. Box 68760, rat or Attending Physician: The law requires that the death certificate be rander death. To Director: After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the bunited in by the funeral director.		F FEMALE: 3b. Was decedent pregnant	in the	23c. If yes, outo	ome of preg	nancy				23d. Date of deliv	•
68 certi	ğ	past 12 months?		1 Live birth 4 Pregnant	at time of de	ath -	Fetal death 3 Other (Specify)	Ectopic p	regriancy	Month	Day Year
30x feath for 1	Š	1 Yes 2 No 9 ✓	Unknown	9 Unknown		3	Other (Specify)				
D. B. the de by the by the sched f	5	Part II. Other significant co	nditions	contributing to dea	ath but not r	esulting in th	e underlying cause	given in Part I	. 23e. Did	tobacco use contribute	to the cause of death?
P.C s that gned e detr	≥	Diphenhydra	mine	intoxic	ation	hypo	thermia d	ue to	1 Ye	es 2 No 3 F	robably 4 🗸 Unknown
cords, P.O. B law requires that the d has been signed by the 2 should be detached	Completed					, <u>/ P</u>	onorma a		 24a. Was	an i 24b. Were	autopsy findings available
Orc aw re as be 2 sho	음	environmen	cal c	old expo	sure				auto		to completion of cause of
Rec The I	ē								1 ✔ Yes		
an:	Be .	25. Was case referred to me	dical				26.Plac	e of Death (Cl	neck only one)		-
Vital Rechysician: The this certificate	<u>.</u>	examiner? 1 ✓ Yes 2 No	H	lospital: 1 Inpa	tient 2	ER/Outpatie	ent 3 DOA	Other,	lursing Home 5	Residence 6 🗸 O	her: Scene
n of ing Ph		27. Manner of Death		28a. Date of Ir (Month, Day	njury (Vest)	28b. Time o	of Injury 28c. Inju	ry at Work?	28d. Describe	how injury occurred	d face down
On endin	Certification:		Pending	Fd 2/2		Fd 23	00 hrs 1	Yes 2 XN	o I.	stream	d lace down
r Att	[일		nvestigatio	28e Place of			reet, factory, office	building, etc.	28f. Location	Street and Number or	Rural Route Number, City
Lis af	;		Could not be letermined		wood	ed are	а		arnold,	State) Jones S MD	tation Road
lospi 4 hou funet		29a. Certifier	n Physici:	an: To the hest of				ate and place		ise(s) and manner as s	tated
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn		(Check only 2 Medical	Examiner	On the basis of ex	amination a	nd/or investi	gation, in my opinior	n, death occur	red at the time, date	e and place, and due to	the cause(s)
To con	Me.	29b. Signature and title of ce		and manner state	d		29c. Licens			29d. Date signed (
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7.4		1111/	0	4	5		0.0.			1 05/daily 20, 2	
10	1	30. Name and address of pe					14 Da O	D-III-	MD 04004		N. P.
0/~		Russell Alexander		Assistant Med			11 Penn Street	, baitimore	;, IVID 27207		
Sta	te	31. Date filed (Month, Day, Ye NAR 03	ar)	32. Regist	rar's Signati	par					
Registr	ell.	MARUO	נטט.	1	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Month CHESTER UILMER JOSEPH 6:30 PM FEB 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL CENTER BALTIMORE 5/LCHRIST OW SON 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**万**M 2□ F 8 16 5201 Director NOV 4 1924 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maryland Examination of the result of the standard of 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 □ No moHOWARD ELLICOTT CIT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 MICHAELS USA 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Pes 2 No 1943 If Yes, Give Year or Dates: 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1943-Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗖 No Specify: WHITE <u>م</u> Specify: 3 M Widowed 4 ☐ Divorced 1946 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) SOCIAL SECURITY Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR ADMINISTRATION 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) HOLDEN William CHESTER LACEY MARY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HNNE STEVENS (OAUGHTER) WOODBINE ROAD WOODBINE, MD 7514 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/3/2009 REST LAWN MEM. GAR. MARRIOTTSVILLE, MO 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JN Zum Brun EH & mon Co. Joffrey 6028 SYKESVILLE ROAD ELDERS BURG MO 21784 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dulminary /Medical Due to (or as a consequence of): Examiner pancreatic months Sequentially list conditions, Examiner to (or as a consequence of): If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e Hospital or Attending Physician: The law requires that the death certificate be executed the burst endeath.

Furbarial Director: After this certificate has been signed by the attending physician and letter birector. After the inequal director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) Residence (**) Other (*Specify) WD \$ \(\text{Spice} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760, To the Hosp within 24 hor To the Fune completely fi

12+1

State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

**Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Charles ST

29d. Date signed (Month, Day, Year)

FELMANY

28 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 25, 2009 **Physician** Phyllis | Meta Coleman 5:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Arden Courts Pikesville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country)
Virginia 6 Sev 7. Age (In yrs. last birthday) **Funeral** 4/14/1926 Days Hours Months 1 □ M 2 🖫 F Director 212-22-9808 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be nutified at Director 1 Yes 2 No Georgia Gwinnett Suwanee 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any inJury or other tranmatic event, Its Macited Extensive mant be no in Jury or other traumatic event, Its Macited Extensive mant be not 5253 Aldeburgh Drive Funeral 30024 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 ∐Yes 2 X No if Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify: Completed by Specify: White 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary **IRS** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Allen Brown Wilhelmina Rutherford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony P. Piacentino / Nephew | 5253 Aldeburgh Drive Suwanee, Georgia 30024 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv. Corp. | 2-27-2009 Towson, Maryland 21. Signature of Apera Service 22. Name and Address of Facility Towson, Maryland 21204 Tank Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MVW /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncriping Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of) physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Į Į 3 Ectopic pregnancy in the past 12 months' 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 D Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown been : 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform this certificate 1 □Yes 2 100 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\triangle \text{ Nursing Home} \) 5 \(\text{ Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) ASSisted 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, after death Director: To the Hospital within 24 hours a To the Funeral D completely

> 7 State

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

Medical

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28, **Physician** Laura Irene Divine February 2009 12:15 anM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Morningside House of Laurel Laurel Prince George's . Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 2□ F Days Hours Min. 157-01-7882 93 Director Nov. 5, 1915 Usual Residence of Decedent the Maryland 10a State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ite Madical Examinar mast by notified at 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Director Lanham 1 ☐ Yes 2 XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7059 Palamar Turn 20706 U.S.A. Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 XXo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates ģ 1 ∐Yes 2**XX**No Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gradé 12 Clerical NJ State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Lowe ပ Laura Lawton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau Charles Divine 7059 Palamar Turn Lanham, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 XX emoval from State Ewing Cemetery 4 Donation 5 Dother (Specify) 3/7/2009 Ewing, New Jersey 21. Signature of Eunoral Service Licensee 22. Name and Address of Facility Donaldson Fuenral Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alzhiemers Disease over 5 year /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause En. Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 🗓 o Day Year 5 ☐ Other (specify) o. ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe certificate I 1 □ Yes 2**X**XV 1 ☐ Yes 2**XX**Vo Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence XXOther (Specify) Hospital: Assisted 1 ☐ Yes 2**X_X**No After this Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Living 28d. Describe how injury occurred or Attending 1 X Matural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 24721 March 3, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14333 Laurel Bowie Road Syed Akbar Sadiq, M.D. Laurel, Maryland 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 03 2009 Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036 Hospital or Attending Physician: The law requires that the death certificate be executed Certification: To within 24 hours after death

To the Funeral Director:
completely filled in by the 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 29b. Signature and title of certifie/ 65843 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road, Randalls town, MD 21133 Old Court 2 401 31. Date filed (Month, Day, 32. Fegistrar's Signature State parka Registrar



29d. Date signed (Month, Day, Year)

,27, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Michael Dalton February 2009 4:40 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Essex

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Nov. 27, 1950 2723 Holly Beach Rd. Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 1**X** M 2 □ F 212-52-4545 58 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 No Md. Baltimore Essex 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2723 Holly Beach Rd. 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1XXVes 2 □ No
If Yes, Give
Year or Dates:Vietnam 1 Never Married Married 1 ☐ Yes 2√√No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Assistant Chief Fire Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edmund N. Dalton Virginia Redman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha A. Dalton/Wife 2723 Holly Beach Rd. Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) Entomb Dulaney Valley Mem. Grd. 3/4/09 |Timonium, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 18 mos. Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Dire to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

ir than "natural", or items 23a or 28a-f sho

death with the Maryland

filed within 72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mental injury or other traumatic event, the Mental injury or other traumatic event.

Baltimore, Maryland 21215-0036

the burial-tran attending physician for use as the buria use as signed by the a signed by has page 2 within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760.

Physician/Medical Examiner IF FEMALE: by Completed Be Certification: To 27. Manner of Death

29a. Certifier

(Check only one)

resulting in death) Last 9 Unknown 25. Was case referred to medical examiner? 1 ☐ Yes 2 No

23b. Was decedent pregnant

Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No

2 Accident 3 Sulcide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier NO CRNP

R097025

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PERRIGNO 1550 ORLEANS ST, IM-16. BALTO, MD 2123 . Registrar's Sign 31. Date filed (Month; Day, Year,

Registrar

104

Medical

To the Hospital within 24 hours a To the Funeral I

			1 - For Amend Item 2	.Ja per dr.,	goos, us Ki	ertificate of	Death	Reg. N	2009	06303
I	1		1. Decedent's Name (First, Middle, L					. Date of Death		3. Time of Death
	Physici /Medic		Frank nougl	as Edwards	3		F	Month D	33 2009	1212 PM
**	Examin		4a. Facility Name (If not institution, g			4b. City, Town, o	r Location of Death		c. County of Deatl	
			Singi Hospit	al of Ba	Himne	Balt.	more C	ity	n/a	
	Funeral				(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Year	9. Birtl	nplace (State or Foreign untry)
	Director		225 62 4789	¹ ⁄₃M ² □ F 59	Yrs.			lar.23,1		ginia
	and		Usual Residence of Decedent 10a. State 10b. County	11	10c. City, Town or	Location				10d. Inside City Limits
	/aryli	jo	MD		Bowie					1 □Yes 2 □ No
	the N	rect	10e. Street and Number	e George		10f. Zip Code		10g. C	itizen of What Cor	X untry?
	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Evaring must be notified at	Funeral Director	12105 FaithLa	ne			715		SA	•
	death	nera	11. Marital Status	12. Was Decedent Eve	er in U.S. 13	B. Was Decedent of I	lispanic Origin? (Speci	fy Yes or No-	14. Race - Amei	rican Indian,
9	after or ite	Ī	1 Never Married 2 Married	Armed Forces? 1 Tyes 2 No If Yes, Give			an, Mexican, Puerto Ri	can, etc.)	Black, White	
21215-003	ral",	d by	3 Widowed 4 Divorced	Year or Dates:		1 □Yes 2 No	Specify:		Specify:bla	.CK
2	72 hc	Completed	15. Decedent's (Specify only highest of	Education grade completed)	ı (G/s	cedent's Usual Occup we kind of work done	during most of working	16b. I	Kind of Business/I	ndustry
2	/ithin ne. han	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)	life	. DO NOT use retire	,			
	lled w Hygie ther t	ပိ	17. Father's Name (First, Middle, La.	_4_years_		Sales	Manager 18. Mother's Name (tomotiv	e
and	be d d	Be	Frank Edwar				Eunice E		,	
Maryland	d 2 should be filed in and Mental Hygi 7 Is marked other traumatic event, It	မ	19a. Informant's Name/Relationship	(Time Print)	10h Ma	iling Address (Street	and Number or Rural I	Pauta Numbar City	ar Tawa State 7	in Code)
<u> </u>	12 s h an 7 Is trau		Linda E. John					-		Va.22039
ā,	ss 1 and 2 of Health item 27 I		20a. Method of Disposition	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		position (Name of ematory or other pla			ocation - City or T	
Baltimore,	Pages nent of int: If its iry or o	33	1 ☐ Burial 2 ☑ remation 3 4 ☐ Donation 5 ☐ Other (Spec			ematory or other pla Mount Cr	Md L.Z.	2009 Ba	ltimore	. bM.
≣	permit. Page Department of Important: If any Injury or once.	Ĭ	2 Signature of Funeral Service Lice							·
ñ	Der Imp any	10	Dernadure	1 / Mary	will	Calvin .	B. Scrugg Preston	s Funer	ar Home	21213
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the	e death. Do not e	enter the mode of dyi	ng, such as cardiac or i	respiratory arrest,	LO PINO P	Approximate Interval Between
	Physician	10	Immediate Cause (Final	ly one cause of each line.	ITC	· Luca	с кепат га	iiiuie	1	Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a	consequence of):	Traire				
	Examiner		Conventially list conditions	Hypert	ension, l	Malignant				10 yrs +
	p ti	iner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying		consequence of).	_				
	ecute and -trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C	es Type	<u> </u>				10 yrs +
g,	cate be executed physician and the burial-transit			, i	consequence of): ipidemia					
58760,	certificate be executed iding physician and se as the burial-transit	dic		d. Hyperi	тыласшта					10 wee +
ROX	eath certific attending p	/Me								10 yrs +
	death of attention		IF FEMALE:	23c. If yes, outcome of	pregnancy				23d Date of deli	
ň		ciar	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at ti	Fetal death 3	B	cy .		23d. Date of deli Month	
o.	t the d by the ached	hysiciar	23b. Was decedent pregnant	1 Live birth 2	Fetal death 3		cy			very
О	s that the d gned by the e detached	y Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2[4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death 3 ime of death 5	Other (specify) _		23e. Did tobacco	Month	very
О	en signed by the ording be detached	ρ	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2[4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death 3 ime of death 5	Other (specify) _			Month use contribute to	very Day Year
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ecords, P.O.	To the Hospital or Attending Physician: The law requires that the owithin 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not 4 Homicide 1 Certifying 29a. Certifier 1 Certifying (Check only 2 Medical Ex	Hospital: 28a. Date of Injury (Month, Day, Yound and the bed of t	Fetal death me of death for a second	underlying cause given the time of the tactory, office ath occurred at the time to the tim	zen in Part I. 26. Place of Death (inter: 4 \sum Nursing Home ry at k? Yes 2 \sum No 28 me, date and place, an opinion, death occurred	1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 N Check only one) 5 Residence d. Describe how injuited. f. Location (Street a City or Town, State at the time, date ar	Month use contribute to ! No 3 Pro 24b. Were aut prior to c death? 1 Yes 6 Other (Speciary occurred and Number or Rule)	the cause of death? bably 4 Monknown copy findings available completion of cause of 2 Mo ify) ral Route Number, stated. to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 2000

06301

Division of Vital Records, P.O. Box 68760,

	1 - State Registrar		Cei	rtificate of I	Death	Re	g.No. ZU	UB	00304
	1. Decedent's Name (First, Middle, Last)					2. Date of Death		Voca	3. Time of Death
sician edical	John J. Fernan	dez Jr.				February		Ye ar 009	4:00 A M
miner	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County o	f Death	
	3 Halbright Court			Tim	onium		Ba	altin	nore
al	5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	lace (State or Foreign
or	215-28-6686	M 2□F 7	7 Yrs.	Months Days	Hours Min.	Feb 20,	1932	Mary	yland
	Usual Residence of Decedent								·
To Be Completed by Funeral Director	10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10	Od. Inside City Limits
용	Maryland Carroll		Westmi	nster					1 □Yes 2 No
Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Coun	try?
a	1207 Weymouth Stree	et		21158	3		USA		
Funeral		2. Was Decedent Ever in U		Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race		
	1 Never Married 💥 Married	Armed Forces? 1 XYes 2 No 19	51	If Yes, specify Cuba				, White, e	
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 19.	53	1∏Yes 2□No	Specify: Spar	ilard	Specify:	Whi	Le
tec	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occup	ation	ing 1	6b. Kind of Bus	iness/Ind	lustry
춵	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	daning most of work	mg			
Completed	9		Comme	rcial Ins	<u>tallatior</u>	ns	Cons	truc	tion
Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	laiden Surname)	
P	John J. Fernandez				Lo	ouise DeG	ano		
_	19a. Informant's Name/Relationship (Typ	ne. Print)	19b. Mailii	ng Address (Street	and Number or Rur	ral Route Number,	City or Town, S	State, Zip	Code)
	Barbara A. Fernand	ez, Wife	1207	Weymouth	Street We	estminste	er, Mary	land	1 21158
	20a. Method of Disposition	20b. I	Place of Dispo	osition (Name of matory or other place	20)	Date 2	Oc. Location - C	City or To	wn, State
	1 ☐ Burial 2 🕅 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			i	12/00	Rolltime	220	Maryland
	21. Signature of Funeral Service License		tro Cro	<u>ematory I</u> 2 Name and Addre	SS of Facility				
	1 - 1 1 1 1 1 1 1 1	11	_ 7	Name and Addre Cremation 299 Frede	Society	Of Maryl	and, Ir	iC Vlar	d 21228
_	23a. Part 1. Enter the disease, or complic	ations that caused the deat						. y 11011.	Approximate
	shock, or heart failure. List only on	e cause on each line.	to Do Hot elli	ter the mode or dyn	ig, such as cardiac	or respiratory arre	31,		Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	mull	uge,	Musice	grae				
	resulting in death)	Due to (or as a consec	uen 🚾 of):	0					
_	Sequentially list conditions, b.								
ine	Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying	Due to (or as a consec	uence of):						
Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last								
	resulting in death) Last	Due to (or as a consec	uence of):						
Medical	d	-							
Med	IF FEMALE:								
	23b. Was decedent pregnant	Bc. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		☐ Ectopic pregnanc	V		23d. Date		
Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of		Other (specify)			Mon	th	Day Year
h	9 Unknown	9 LI UNKNOWN							
by P	Part II. Other significant conditions con	tributing to death but not res	7		en in Part I.	23e. Did tob	acco use contri	bute to th	e cause of death?
ğ D	Conone	or her y	- Ve	selval		1 ☐ Ye	s 2 No 3	3 ☐ Prob	ably 4 Unknown
<u> </u>		\ 1				24a. Was an	24h W	ere autor	osy findings available
Completed						autopsy	/ _ pr	ior to cor	npletion of cause of
						1 □Yes 2	₩No 1		2 □ No
D	25. Was case referred to medical examiner?	ospital:		nt 3 🗆 DOA Oth	or:	h (Check only one			Daughter's
2	I les ZENO	1 Inpatient 2 L		IN 3 II DON	4 Li Nursing Hu	ome 5 Reside			Residence -
Ö	27. Mannor of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Worl	Ŕ?	28d. Describe how	w injury occurre	d	
cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	-			Yes 2 □No				
Certification: To	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str <i>fy)</i>	reet, factory, office		28f. Location (Str. City or Town,	eet and Numbe State)	r or Rura	Route Number,
Š									
cal		ician: To the best of my kneer: On the basis of examination							
Medical	one)	and manner stated.							
Σ	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed	(Month, L	Day, Year)
				Dong	0763		3/3/9		
	30. Name and address of person who con	mpleted cause of death (De	n 23a) (Type,						
	Ernesto Mendoza				oad, Wes	tminste	er, MD	21	157
te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	2)					
strar	MAR 0 3 2009	32. Registrar's Signa	face						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, perrh 8889 3/23/09 TT

State of Maryland / Department of Health and Mental Hygiene 06305 Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Mary M. Fickert February 25, 2009 10:51 a^M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 212-34-9937 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🛛 F Months Days Hours Min. Maryland October 18,1936 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Balto White MArsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21162 5307 Bangert Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook <u>St. Stephen Cath. Ch.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Angevine Mary Ellen Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore A. Fickert Spouse 5307 Bangert Street White Marsh, Md. 21162 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview 2-27-2009 Balto. City, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md. 21236 s L 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ventrialar Due to (or as a consequence of) Due to (or as a requence of): arter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Ye a 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Inte 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an mozlud autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1√ Natural Injury 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner physician and street transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transi P.O. Box 68760, of Vital Records, Division

Physician

/Medical

Examiner

10a. State

Md.

Director

Funeral

2

Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian D. partment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modlea Executive must be notified at

Physician

/Medical

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Certification: To

Medical

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31. Date filed (Month, Day,

Fickert, Morul altimore, Maryland 21215-0036

29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Marie D20907 2/25/09 lucti MI

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N. Cherly St. Registrar's Signature MAR 03 2009

			For State Registrar	State of Mar	ryland	•	artment of F ctificate of				giene Reg. No.	009	06306
			Decedent's Name (First, Middle, La	st)					2.	Date of Dea	th	000	3. Time of Death
	Physicia /Medic		MARGARET KATHE	RINE FOGAR	TY				FEI	Month 3RUAR	Y E7	Year 2212	19 05:30AM
,	Examin		4a. Facility Name (If not institution, given Saint Joseph	e street and number) Medical	Cen	ter	4b. City, Town, o		of Death	٦	4c. Co	ounty of Deat Bal	timore
	Funeral		Social Security Number 6. 8	777 -		st birthday)	If Under 1 Year Months Days	If Unde Hours	r 24 Hrs. 8.	Date of Birtl (Month, Day	Year)	9. Birt	hplace (State or Foreign
	Director		220-05-2759	I□M 2 X) F	89	Yrs.	Worling Days	110013		ec. 5,			yland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation			_			10d. Inside City Limits
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	n the	Director	10e. Street and Number	nore		WSOII	10f. Zip Code				l0g. Citizer	n of What Co	untry?
	th wit		1055 W. Joppa Ro	ad			21	204				U.S	.A.
	tems tems	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		. 13. V	Vas Decedent of H f Yes, specify Cuba	lispanic O an, Mexica	rigin? (Specifon, Puerto Ric	y Yes or No- an, etc.)	14.	Race - Ame Black, White	
36	be filed within 72 hours after death with the Maryland that Hygliene. ed other than "natural", or items 23a or 28a-f show event, it is Medical Exertifier mast be redflied at	by F	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 No If Yes, Give Year or Dates;)	1	□Yes 2√ No	Specify	<i>/</i> :		Sp	pecify: Wh	ite
2-0036	2 hou		15. Decedent's E	ducation		16a. Deced	lent's Usual Occup	ation			16b. Kind	of Business/	
בוצ	hin 72 e. an "ni Medi	ple	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)		(Give life. L	kind of work done OO NOT use retired	during mo: d)	st of working				
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yland	ould be file Mental H iarked oth	Be	17. Father's Name (First, Middle, Last						ner's Name <i>(F</i>			•	
ž	2 should be n and Mental is marked or raumatic ev	2	Philip Fos	garty		10h Mailin	g Address (Street		izabeth		Bott		Zin Cada)
Mar	id 2 s Ilth an 27 is i		Maureen Fogarty	(niece)	۱ I		te Pine		Cockey				•
စ်	s t ar of Hea item	1	20a. Method of Disposition				sition (Name of natory or other place		Date			ation - City or	
Ë	Page:		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		i		Cemetery		3-3-0	9	Wood	lawn.	Maryland
saitimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic en	ì	21. Signature of Funeral Service Licer	isee		22	Name and Addre	ss of Facil	efeld F	unera			
_	402 40		23a. Part 1. Sofer the disease, or com	plications that caused the	ne death	Do not ente	titchell- 500 York	Road	l Balt	imore	, Mar	yland	21212 Approximate
		0.2	shock, or heart failure. List only Immediate Cause (Final	one cause on each line		Do not one	or the mode of dyn	ig, suci i a	o dardido or re	ospiratory an	031,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. FNEUMO Due to (or es a		ence of):							
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p.	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. SEPTIC Due to (or as a									
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20	ificate g phys	edical		_ d									
X Q Q	death certif e attending d for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2			Ectopic pregnanc	v			230	d. Date of deli	
	e law requires that the death certifi has been signed by the attending ie 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown			Other (specify) _					Month	Day Year
ν, T	s that med b	by Pi	Part II. Other significant conditions	ontributing to death but	not result	ing in the un	derlying cause giv	en in Part	l.	23e. Did to	bacco use	contribute to	the cause of death?
	en sig	ed b	ACUTE RESPIRAT	ORY DISTR	ESS	SYNI	ROME			1 □ Y	es 2 🗆 N	No 3□ Pr	obably 4 Dunknown
Hecord	The law requires that the ate has been signed by the bage 2 should be detache	Completed							[24a. Was a	in 2 Sy m è d?/	24b. Were au prior to death?	topsy findings available completion of cause of
	n: Th ficate or, pag		25. Was case referred to medical							1 🗆 Yes	2 No	1 ☐ Yes	2 1 2 No
VITAI	s certi	o Be	examiner?	Hospital:	2□F	B/Outnation	t 3 DOA Oth	or.	e of Death (C			☐Other (Spec	-16.1
וסו	ig Phy ter this neral o	J:U	27. Manger of Death	28a. Date of Injury	2	28b. Time of Injury	28c. Injur Worl	y at	_	. Describe h			city)
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	l or Att after de Direct d in by t	Certification: To	3 Suicide 6 Could not b 4 Homicide determined		/ • At hom (Specify)	ne, farm, stre	eet, factory, office		28f.	Location (S City or Town	treet and N n, State)	Number or Ru	ral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying PI (Check only one)	nysician: To the best of niter: On the basis of e and manner state	examinatio	ledge, death on and/or inv	occurred at the tile restigation, in my co	me, date a ppinion, de	and place, and eath occurred	due to the oat the time, o	ause(s) ar late and pla	nd manner as lace, and due	s stated. to the cause(s)
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	12			completed cause of dea				1 1 pm	source proving a grand con-	1			,
F	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar	s Signatu	re	LER DRI	VE	TOWSO	IN, MAI	(YLAN	4D 218	V14
	Registra	ar	MAR 0 3 200	19 Certura	, ß.	100	N.						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 TRENE GOLDIE FORYS February 5:15P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Commons Baltimore Catonsville 8. Date of Birth (Month, Day, Year) (mher 17, 1920 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Min. Months Hours 233-26-9439 88 Pennsylvania Director Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must be notified an once. 1 □Yes 2 → No Director Marvland Baltimore White Marsh 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5318 Millfield Road 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 □Yes XX No Specify White à 3XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rich Joseph Julia Solosha ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Mary Waldt Dtr/POA 20 Deer Run Court #G Halethorpe, Maryland 21227 Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Gar 3/2/09 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fach TCHELL-WIEDEFELD FUNERAL HOME INC. Ignature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ancreatic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy med? 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 174 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 TYes 6 ☐ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McCornick Rd Hunt Valley 11311 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 - For State of Maryland / Department of Health and Mental Hygiene (1970) | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 1980 | 19

1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Day Month **Physician** Mary Alice Francis 17 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FRANKLIN SQUARE HOSPITAL CENTER Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Apr. 22, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗙 F 216-14-1837 85 1923 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show Iry or other traumatic event, the Modical Examinat must be notified at MD **Baltimore Parkville** 1 ☐ Yes 2 No Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 8800 Walther Blvd. # 3322 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 □Yes 2 No Specify: White 21215-0036 Specify: <u>چ</u> If Yes. Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own home 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Frederick Franklin Lookenott Frances Mildred Clossman ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau George Francis - Spouse 8800 Walther Blvd. #3322 Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board, 655 West 21. Signature of Funeral Service Licensee Ronald S. Wade per DVR Baltimore Street, Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiopulmonary
Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Infarction myocardial Acute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Arter Coronary disease ending physician and use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) ģ in the past 12 months? Month Year signed by the a d be detached for 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, δ HearT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Failure been s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has i page 2 s autopsy performed? certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☑ No or Attending Physician: after death. within 24 hours after death.

To the Funeral Director: After this certific.
completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29c. License number 29b. Signature and title of certifien 064408 2-17-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN Square DR Balto ind 21237 BeHari

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

5

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ^{Day} 27, John P. Fromm Month February 2009 3:15 P M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2120 Cedar Circle Drive Catonsville Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 X M 2 ☐ F 216-16-8442 Director 86 Oct. 8, 1922 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County if than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 📉 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 Cedar Circle Drive 21228 USA Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 ZaYes 2 ☐ No filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 🛛 No Specify. ģ White 3 Nidowed 4 Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Manager Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental George W. Fromm Mary Stegman traumatic 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trai once. Mary Patricia Ball Daughter 2120 Cedar Circle Drive; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐XCremation 3 ☐ Removal from State Atlantic Crematory 3/3/2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 21. Signature of Eugeral Service Licenses 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc .630 Edmondson Avenue; Catonsville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 4800 /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) Day the signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of do th? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 V Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an certificate 1 □ Yes 2 🗆 No 20 1 🗆 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 \sum Nursing Home Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Man r of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 2 Accident 1 ☐ Yes 2 🔲 No after death Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the i 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Jimmy Gee February P^{M} 28 2009 5:40 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Washington Med Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F 110-40-0832 60 **Director** 09/12/1948 New York Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exactine must be notified at MD Anne Arundel Severn 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö 23a 903 Merriweather Way 21144 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Myes 2 No 1968− If Yes, Give Year or Dates: 1988 72 hours after 1 ☐ Never Married 2 🔀 Married 3altimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify. Specify. δ 3 ☐ Widowed 4 ☐ Divorced Asian Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communication Government 12 should be filed w h and Mental Hygie 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evones. Doo Kan Gee Soo Mei Hom ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1111 11th St.NW, Apt. 307, Washington, D.C. 20001 Johnny Gee/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Cremation Services 03/02/2009 | Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral 5, rvice Licensee 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): BOTH LEGS Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami burial-transi Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown 9 Unknown Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Š 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 1 □ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🕽 🗸 🗸 🗸 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day, Year) 27. Manns of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

DHMH 17 Rev 1/2001

Registrar

29b. Signature

31. Date filed (Month, Day

ef pesson who completed cause of Both (Item 23a) (Tyle Print)

29d. Date signed (Month, Day, Year)

FEBRUARY 28, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 06311 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Terry Lindale Grimes February 2009 2:30 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year, Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1**∑** M 2□ F 49 220-76-6042 Director 18, Dec Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be muithed at 10d. Inside City Limits Directo 1 ☐ Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 69 Old Mill Bottom Road Funeral 21401 USA death permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". or itemone. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married 1 ☐ Yes 2X No Specify: \$ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Recycler/Welder Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be ည Wrightson Grimes Frances Duckett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deborah Grimes, Wife <u>69 Old Mill Bottom Road Annapolis, Maryland 21401</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. | 02/28/09 Baltimore, Maryland ²² Name and Address of Facility
Cremation Society Of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Acenses
Infomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran Due to (or as a consequence of) Box 68760. physician The law requires that the death certificate be Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery atter for u 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death signed by the a 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending Natural 5 Pending within 24 hours after death.

To the Funeral Director; A completely filled in by the fu death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Certifying Physician: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of 29c. License number

Registrar DHMH 17 Rev 1/2001 32. Registrar's S

116376

29d. Date signed (Month, Day, Year)

	1	For State Registrar		State of	Maryla		epartment Sertificate			d Mental F	lygiene Reg. No.	-114	0631
Physician /Medical Examiner		a. Facility Name	holas C	harles Ghi				own, or Lo	ocation of De	2. Date of Month Februath	Death Day Jary 26	Year 2009 County of Deat	h
Funeral Director		i. Social Security I	Number 8693		. Age (In yrs		(ay) If Under 1	Year I	Under 24 H Hours Mi	n. (Month,	Birth Day, Year) 2, 1915	Baltim 9. Birt Co New	iore hplace (State or Foreig untry) York
-0036 hours after death with the Maryland hours after death with the Maryland tural", or items 23a or 28a-f show levering must be notified at ed by Funeral Director		0a. State MD 0e. Street and Nu	10b. County Baltim	ore		City, Town o	lle						10d. Inside City Limit
1036 urs after death with the Marylan al", or items 23a or 28a-f show Evaminat must be notified at 1 by Funeral Director	1	322 Wave		ad 12. Was Deced	ent Ever in l	J.S.	10f. Zip C 2122 3. Was Decede If Yes, specif	28	anic Origin?	(Specify Yes or	USA	en of What Co	rican Indian,
- 72 - 73 - 74 - 75 - 75 - 75 - 75 - 75 - 75 - 75	2	3X Widowed	15. Decedent' cify only highes	1 X Yes 2 If Yes, Give Year or Date	:□No es: WWII	16a. De	1 □Yes X ecedent's Usual ive kind of work e. DO NOT use	No S	Specify:			Black, White Specify: White d of Business/I	ite
Tallyiding 2 1 Z 2 should be filed within 1 and Mental Hygiene. is marked other than raumatic event, ITEM TO Be Comp	1	7. Father's Name	(First, Middle, L	<u> </u>	or 5+)	Сар	tain		Mother's N	ame (First, Midd		nant Ma urname)	rines
		19a. Informant's N Timothy	T. Ghiz			19b. M 322	ailing Address (S Wavelan	Street and	Number or l	Rural Route Nur onsvill	nber, City or	Town, State, Z 21228	ip Code)
Dearmit. Pages 1 ar Department of Hea Mportant: If item any injury or othe		4 ☐ Donation	☐ Cremation : 5 ☐ Other (Sp		wo.	cemetery, o	sposition (Name crematory or other n Cemete	er place) E ry	3/3/		Wood1	ation - City or T	•
cate be executed by leading the burial-transit the burial-transit calcal Examiner	Siling	23a. Part 1. Enter the shock, or head mendiate Cause issease or condition conditions and the sulting in death) Sequentially list conditions and the sulting in death in the sulting in death in the sulting in death) in the sulting in death in the sulting in the	the disease, art failure. List of (Final on on one of the original on one of the original of t	b	sed the dea h line. as a consect as a consect as a consect are me of pregn	quence of): quence of): quence of):	riA	eric	K Ka (atonsvi	IIE, M	d. Date of deliv	Approximate Interval Between Onset and Death
ne law requires that the de has been signed by the ge 2 should be detached mpleted by Physion		in the past 12 1 □ Yes 2 [9 □ Unknown art II. Other signif	□No	1 □ Live birt 4 □ Pregnari 9 □ Unknow s contributing to deat	nt at time of	death	3 □ Ectopic preg 5 □ Other (spec e underlying caus	ify)	ı Part I.	1 C 24a. Wa aut	s an opsy formed?	Month contribute to the contr	the cause of death? bably 4 Unknown opsy findings available ompletion of cause of
r Attending Physician: ler death. irector: After this certific by the funeral director, i tffication: To Be C	2	5. Was case referexaminer? 1 Yes 2 7. Manner of Death 1 Accident 3 Suicide 4 Homicide	No	28a. Date of I (Month,	njury Day, Year)	28b. Time Injur	ient 3 DOA of 28c. M 28c.	Other: Injury at Work? 1 □ Yes		1 □ Yes eath (Check only Home 5 □ Re 28d. Describe 28f. Location City or To	sidence 6 [e how injury o	occurred	
To the Hospital of within 24 hours at To the Funeral Discompletely filled in Medical Cer	2	9b. Signature end	tip of certifier	Physician: To the becaminer: On the basis and manner	s or examina stated.	A~	29c. L	my opinio	on, death occ mber	eurred at the time	e, date and place. 29d. Date s	ace, and due to	o the cause(s)
State Registrar	-	Date filed (Moor	EY	o completed cause of a second	f death (Iter	10	4660	W	LKEN	9 us Ave	E. C	BATA	1) 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2009 06313 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death MONTAR **Physician** REIF /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TINVRE N/A USPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 23, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F 1915 213-01-2101 93 Yrs Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show instriust be notified at 1 Yes 2 No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 U.S.A. 600 Light Street Apt. 811 21230 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 No White Specify: 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Dental Office Secretary . Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If Item 27 Is marked other t jury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Hitzelberger Catherine Haschert ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward G. Kern (Son) 1702 Woodholme Court, Salisbury, Maryland 21804 Department of Heal Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Parkwood Cometery

22 Name and Address of Facility
Mchilly-Polyniak Funeral Home P.A.

T30 Fast Fort Avenue, Baltimore, Maryland 21230 Parkville, Maryland permit. 21. Signature of Funeral Service License . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) 0 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to or as a consequence of The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) P.O. 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗹 No 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 I Nursing Home 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Man of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Injury 5 Pending within 24 hours after death.

To the Funeral Director: /
completely filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMORE NO 21202

DHMH 17 Rev 1/2001

State

Registrar

OSEPH

MAR 03

31. Date filed (Month, Day, Year)

57.

581

Registrar's Signatur

32.

09-01675 Robyn Gonis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 06314

lobyii Coms		- For State Registrar	C	ertificate of			ے U (g. No.	33 0031
Physicia Medical Examir	n/	1. Decedent's Name (First, M Robin Goins	ddle,Last)	COINS, SR.		2. Date of Deat Month February 2	h	3. Time of Death 1342 hrs
		4a. Facility Name (if not instit Harbor Hospital	ution, give street and number)	41	o. City, Town, or Location of Baltimore		4c. County of Death	n .
Funeral Director		5. Social Security Number 047–44–1371	6. Sex 7. Age (in yr	s. last birthday) 58 Yrs.	If Under 1 Year If Under Months Days Hours			rthplace (State or gn puntry) Georgia
/aryland 28a-f show any 1.at once.	or.	Usual Residence of Deceden 10a. State 10b. Cour Maryland		ity, Town or Locatio	Baltim			10d. Inside City Limits 1 X Yes 2 No
with the Maryland ms 23a or 28a-f sho be notified at once	oi.e	10e. Street and Number	4109 Morrison Court		10f. Zip Code 2122		og. Citizen of What Cou USA	ntry?
fler death	ed by Funeral	15. Decedent's Education (S	1 Yes 2 A No Divorced If Yes, Give Year or Dates: Specify only highest grade completed	o If Ye	Decedent of Hispanic Origs, specify Cuban, Mexican, Yes 2 X No specify: S Usual Occupation (Give st of working life. DO NOT	, Puerto Rican, etc.)	White, etc.	nican Indian, Black, Nite Vindustry
15-0036 filed within 72 l I Hygiene. et other than "; t, the Medical E	Completed	Elementary/Secondary (0- 9	College (1-4 or 5+)	Ca	onstruction		Pipefitter U	Inion
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Mid Johnni	_{dle, Last)} e Le e Goins			's Name (First, Middle, I adys Virginia		rec
MD 2121 and 2 should be f lealth and Mental ten 27 is marked traumatic event,		19a. Informant's Name/Relati Shirley Ann Go			Address (Street and Num Morrison Court			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matura injury or other traumatic event, the Medical Examiningury		4 Donation 5 Othe	tion 3 Removal from State	crematory or othe Bayview Crem	matory, Inc.	3/2/09	Baltimore,	Maryland
	- 1	With h	rice Licensee Kevin E Ecke		ame and Address of Facility 37 E. Patapsco			A STATE OF THE PARTY OF THE PAR
Physician 'Ledical caminer		23a. Part I. Enter the disease failure. List only one ca Immediate Cause (Final dise or condition resulting in deat	ase a. Hypertensive Athero	sclerotic Cardio		cardiac or respiratory arr	est, snock, or neart	Approximate Interval Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Car	b	ce of):				
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, P.O. B res that the d			nditions contributing to death but n		nderlying cause given in Pa		obacco use contribute to	
Division of Vital Records, P.O. Box 687 fo the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Completed by	Chilothic obstructiv	e politionary disease, diabe	tes memos			prior to rmed? death?	autopsy findings available completion of cause of
tal Recian: The	Be	25. Was case referred to me examiner?	I Hoonital:	T EDIO ALLENIA	26.Place of Death		Residence 6 Oth	
n of Vi ling Physi After this funeral di	유	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	✓ ER/Outpatient 28b. Time of Ir			how injury occurred	er.
Division of Vital Records, bopital or Attending Physician: The law require hours after death. Interal Director: After this certificate has been siy filled in by the funeral director, page 2 should be	Certification:	2 Accident 3 Suicide 6	Pending nvestigation	At home, farm, stree	1 Yes 2 t, factory, office building, e			Rural Route Number, City
Fo the Hospital within 24 hours a To the Funeral completely filled	Medical Ce		g Physician: To the best of my know Examiner:On the basis of examination					
F × F 8	Me	29b. Signature and title of ce		1	29c. License number O.C.M.E.		29d. Date signed (M February 27, 20	
6	ŀ	30. Name and address of pe Zabiullah Ali, M.D.	rson who completed cause of death (Assistant Medical Examin		n Street, Baltimore,	MD 21201	, , , , ,	
St Regist		31. Date filed (Month, Day, Yo	ear) 32. Registrar's Sig					
100 01	-	196 Ft Lat 14 . T	AND THE PROPERTY OF THE PARTY O	# T				

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27^{Day} Month Roy J. Goins 2009 Feb. 10:15pm 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Holly Hill Nursing Center Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. | 2, 1940 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 228-54-0620 1 M 2 ☐ F 68 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Middle River 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Honeycomb Road 21220 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Produce Co. 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William H. Goins Eva Hurd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patti Goins / wife 3 Honeycomb Road Baltimore MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Bayview 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crematory Baltimore MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 30'0 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or composhock, or heart failure. List only reations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, be cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 27 do ue to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unlease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? 1□ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 1 🖂 Inpatient 2 ER/Outpatient 3 DDA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

29c, License number

#301

Towsen

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner The law requires that the death certificate be executed

Hospital or Attending Physician:

124 hours af

To the I within 2

Division or

Physician

/Medical

Examiner

MD

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Completed

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Certification:

Medical

29b. Signature and title of certifier

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any inJury or other tranmatic event, the Medical Examine

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 ⊡Natural 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

			1 - For State Registrar	State of Maryla			nt of H			Reg. No.	9	06316
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last) Thomas A. 4a. Facility Name (If not institution, give s	Gorman,	3rd	4b. Cit	y, Town, or	Location of D		eath Day 4c. County		3. Time of Death 6:22 a M
Ť	Funeral	***	Brightwood 5. Social Security Number 6. Sex		rs. last birthday)		er 1 Year	erville	Hrs 0 Date of B	-a-lo	Cour	place (State or Foreign
*	Director		215-22-9853 1 Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo		Lays	110013	March	13,1928	Penn	Od. tnside City Limits
	h the Mary r 28a-f sh r notified	Director	MD Baltim 10e. Street and Number	ore	Timoni		ip Code			10g. Citizen of	What Cour	1 ☐ Yes 2 🎇 No
	death with	Funeral D	311 East Timonium 11. Marital Status	Road 2. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Dec	2109		? (Specify Yes or Nuerto Rican, etc.)	U.S.,	e - Americ	
0036	hours after tural', or it.	þ	1 Never Married 2X Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 🗆 Yes	2 X No	Specify:	dello ricali, etc.)	Specif	ck, White, y: Whi	te
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or items 23a or 28a-f show uth, the Medical Examiner, ust be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			kind of w DO NOT	rork done d use retired,	ation furing most of 'esiden		Mechai		Contractin
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28af show any injury or other traumatic event, the Middlet Examiner must be notified at ance.	To Be C	17. Father's Name (First, Middle, Last) Thomas A.	Gorman				Emm		.ce S	Shaff	
e, Mar	1 and 2 sh Health and em 27 is m ther traum		19a. Informant's Name/Relationship (Type Betty J. Gorman-w 20a. Method of Disposition	ife	311	E. T	imoni	um Rd.	Rural Route Numb , Timoniu	m, MD 2	21093	
Baltimore,	iit. Pages artment of ortant: If it njury or o		1X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Dulaney	Vall	ey	3/	2/09	7 i mon	ium,	MD
Ba	Depa Depa Impo eny i		21. Signature of Funeral Service Lipense 23a. Part 1. Enter the disease, or complice			1050	York	Rd.,	uck Towso Towson, M	D 21204	al Hoi	me, Inc.
*	Physician /Medical Examiner whisician and physician and physician and physician and the physician and	i Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Due to (or as a cons Due to (or as a cons	on the sequence of): Sequence of): Sequence of):	iani		dise	vk.			Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of pre, 1 Live birth 2 Fig. 4 Pregnant at time of 9 Unknown	gnancy etal death 3		pregnancy				te of delive	ry Day Year
cords, F	w requires the been signed should be de	þ	Part II. Other significant conditions cont	ributing to death but not r	resulting in the ur	nderlying	cause give	n in Part I.	10	Yes 2□No	3 Prob	
Vital Records,		e Completed	25. Was case referred to medical		300		7 Table 1971	26 Place of I	24a. Was auto perfo	psy prmed? 2 No	prior to con death?	osy findings available inpletion of cause of
Ö	ling Phys 1. After this tuneral di	ation: To B	examiner? 1 Yes 2 No 27. Manny of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1	ER/Outpatient 28b. Time of Injury		OA Othe 28c. Injury Work	r: 4 Nursin	g Home 5 ☐ Resi)
Division	7 9 7 6	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury · Al building, etc. (Spe	ocify)				City or To			
	To the Hospital or within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier 11 Certifying Physic (Check only one) 2 Medical Examination one)	cian: To the best of my k r: On the basis of exami and manner stated.	nowledge, death ination and/or inv	estigation	n, in my op	inion, death or	ccurred at the time,	date and place,	and due to	the cause(s)
l	J. W. CO.		1				D 5	274°		29d. Date signed		
**	\2 Sta	e	30. Name and ad ss of person who con start in the start i	npleted cause of death (It	uster:	3 yn	4,7	Prinder	on v	2120	4	
	Registr		MAR () 3 2009	Mour	A. Sa	A.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2 Year Arnold Henderson 8:2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/AUnion Memorial Hospital Baltimore 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Months Days Hours Min 220-82-9630 46 Director June 17,1962 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 28a-f show 10d. Inside City Limits s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 22 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the flexical Everting crount be mallfact Director 1 ☐Yes 2 ☐ No N/ABaltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 2750 The alameda 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 🎇 ☐ No Specify: 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Safeway Stock Clerk 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Doris Briscoe Wesley Henderson, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any Injury or other traun once. Valerie J. Henderson/ Wife 2750 The Alameda Baltimore, Maryland 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 Removal from State Woodlawn Cemetery 2/27/09 Woodlawn, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Fur eral Service Linenser 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 sevi 3a. Par Enter the disease, or complications that caused ock, or heart failure. List only one cause on each li or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause inal disease or condition resulting in death) Onset and Death **Physician** 1005 /Medical Due to (or a a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to or as a consequence of burial-transit physician and the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, pe Physician/Medical attending p IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) signed by the ad be detached to 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s was a autopsy performed? certificate 2 🗆 No 1 □ Yes 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA After this funeral dir 27. Manner of Death 1 Natural To the Hospital or Attending P. within 24 hours after death.
To the Funeral Director: After the completely filled in by the funera 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

30. Name and

31. Date filed (Month, Day,

Year.

MAR 0 3 2009

ddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

nior

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William J. Haacke, Jr. 02-24-2009 950 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Ceneter BelAir Harford | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0.2-21-1948 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 217-50-2725 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show r than "natural", or items 23a or 28a-f show Director MD 1 ☐ Yes 2√ No Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3908 York Drive 21014 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes _ 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X No Specify. ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ran injury or other traumatic event, It = Med once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrical Mftg. Rep. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William J. Haacke, Sr. Bertha Pfiel ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Haacke 3908 York Dr Havre de Grace, MD 21078 (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 02-27-2009 Baltimore, MD 21. Signature of Funera 22. Name and Address of Facility Schimunek Funeral Home of BelAir 610 W. MacPhail Rd BelAir, MD 21014 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hemorrhage **Physician** Intracranial /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any healing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes 2 🗹 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 W Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier

To the Hospital or Attending Physician: The law requires that the death certrind within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 63420 February 24,2009 Cohn Klyen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Chesapeake Drive, Bel Air MD 21014 Sid 2- Kharal 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 0 3 2009 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		Certifica			vieniai riy	Reg. No.	2009	063	19	
	Physici		1. Decedent's Name (First, Middle, Last)	EP					2. Date of Dea Month Februar		2, 2009	3. Time of Dea 1:55 PM		
	/Medic Examin		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				County of Death			
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. other than "natural", or items 23a or 28a-f show ant, it Medical Examination in the filed at		Suburban Hospital Sethesda Montgomery Social Security Number Social Securi								-	oreign		
			309-36-1670 1 M 2 □ F 71 Yrs. Months Days Hours Min. Jan 8, 1938 Country) unk											
			Usual Residence of Decedent 10a. State											
		ctor	MD Montgome	В	Bethesda						1 □ Yes 2	X No		
		by Funeral Director	10e. Street and Number 5721 Grovsenor Lane				10f. Zip Code 20814				10g. Citizen of What Country? USA			
		uner	Tr. Marian States	Armed Forces?	. Was Decedent Ever in U.S. Armed Forces? unk		Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica			-	14. Race - American Indian, Black, White, etc.			
336	urs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 □ No If Yes, Give Year or Dates:	unk	1 □ Yes	2 X No	Specify:			Specify: b	lack		
5-0	permit. Pages 1 and 2 should be filed within 72 hours: Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural"; any injury or other traumatic event, it is the Jical Exagnee.	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a.	Decedent's Us (Give kind of v	work done	during most of work	unk ding	16b. Ki	nd of Business/In	dustry U	ınk	
2121		Completed	Elementary/Secondary (0-12) College (1-4or 5+) unk unk											
and		Be	17. Father's Name (First, Middle, Last)				unk	18. Mother's Nam	e (First, Middle,	Maiden	Surname)	ur	nk	
Baltimore, Maryland 21215-0036		To	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8600 Old Georgetown Road Bethesda, MD 20814											
			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 ☒ Other (Specify)	emoval from State	20b. Place of cemeter	Disposition (N y, crematory or	lame of r other pla		Date	20c. Lo	ocation - City or To	own, State		
			21. Signature of Euroral Service Licensage Ronald S. Wades Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201											
5			23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the e cause on each line.	death. Do n					rest,		Approximate Interval Betwee	en	
	Physician /Medical		Immediate Cause (Final disease or condition a. ASPIRATED PROUMBNIS											
0	Examiner			Due to (or as a co	ansequence o	n):								
55 pm	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):										
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9 X0	n certifi ending l use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 2	c. If yes, outcome of pregnancy					2	23d. Date of delivery				
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Apro	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	ted t		ANCEC FI	COSTAT	L			101	/es 2[□ No 3 □ Pro			
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IFF, W		Medical Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
土		dical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10. 2009 Delbert F. Horwath February 3:50 AMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Mallard Bay Nursing Home Cambridge Dorchester 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 X M 2 □ F 81 July 29, 218-20-6746 Director 1927 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director MD Dorchester 1 □Yes 2√2 No Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 510 Academy Street 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 144-5 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ② No Specify: þ 3 Widowed 4 □ Divorced Specify: white 44-58 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: if Item 27 is marked other tha any injury or other traumatic events. 6 self employed waterman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mitchel Walter Horwath Frieda Ann Neihausmyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mallard Bay Nursing Home 520 Glenburn Avenue Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servi Ronald 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 irector 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 2006 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy certificate 1 □Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 No within 24 hours after deat To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifiei (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

State Registrar 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiere 0009

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 6:30 A M -e6 7 2009 /Medical Mildred Holmes 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Esthers Place Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) Months 1 □ M 2 🖾 F Davs Hours Apr 8, Director 229-26-9447 Virginia Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, It a Modical Execution must be notified at 1√ Yes 2 No MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2901 E. Strathmore Avenue 21214 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other than "natural", or Itar 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1

Never Married 2

Married 1 ☐ Yes 2 ☑ No Specify: Specify: black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk disabled none unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 st of Health ar fitam 27 If Esthers Place 2901 E. Strathmore Avenue Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of He
Important: If itan
any injury or oth 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State '4 □Donation 5 NOther (Specify) in state 21. Signature | Juneral Service Licensee Ronald S. Wade, Difector State Anatomy Board 655 W. Baltimore Street m Baltimore, MD 21201 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician MYOCAROLAC INFARCTION Lour /Medical Due to (or as a consequence of): Examiner CORONARY DUSCHJe Ye Ares Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIMBETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Esthers examiner Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Place 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Assisted 1 Matural 5 Pendina death. 1 ☐ Yes 2 ☐ No investigation М LIVERA 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m. Mi Trabacca 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MCNabray Mathlew Egitera 31. Date filed (Month, Day, Year) 2. Registrar's Signature -State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Shirley E. Hatmaker Month 2:25 PM FEBRUARY 200 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town-or Location of Death 4c. County of Death INISTA MEDICAL LATF ENTER Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/07/1928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months Days 268-26-5570 80 **Director** OH Usual Residence of Decedent death with the Maryland 10a. State 10b. County show i 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Everning in ust by notified an once. MI Oakland Director Oak Park Y⊆Yes 2 No 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 23111 Forest 48237 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 ∐Yes **2**K⊒No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: White <u>8</u> Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Public Schools 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) William Glick Loretta Footlick ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol A. Powers / Daughter 2312 Oxford Shire Ct. Waldorf, MD 20603 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 € Removal from State Roseland Park Cemetery 3/6/2009 Berkley, MI 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 Fast Fort Avenue, Baltimore, MD 21230 21. Signature of Funeral Service Licensee Dorota Marshall Mardial 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE **Physician** HEART disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the a Ö σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š SEIZMRE director, page 2 should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown INFECTION UZINARY 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an certificate METABU 2 MNo 1 □Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director: After this

filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 8) av D 44436 MARCH 012009 30. Name and address of person who completed cause of depth (Item 23a) (Type, Print) PAUL MILLIA CT ASHVINKUMAR 1 ATEL

Registrar

31. Date filed (Month, Day, Year)

MAR 0 3 2009

SHIRLE

37 Registrar's Signature

WALDORF MD) 20602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2009 Day **Physician** Dorothy Joyce Horne 5:35AM Feb 24 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner hospital Baltimole Agnes N/A 8. Date of Birth (Month, Day, Nov. 26, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Maryland 1 ☐ M, 21 F Months Days Hours 213-28-3181 77 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, I'm Mc Ilical Extraction must be notified at 1 □Yes 2 No Director MD Anne Arundel Linthicum Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1101 Furnace Road 21090 United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EKG Technician Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Otis Bruce Dorothy Brown ပ permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is marl any injury or other traumationce. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll H. Horne, Sr./Husband 1101 Furnace Road, Linthicum Heights, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 2-28-09 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Qther (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral accice Licensee 1328 Sulphur Spring Road, Arbutus, MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myoraldia **Physician** hrs /Medical Due to (or as a consequence of): Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent of): Examiner Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, 🛇 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy ģ Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) as been signed by the 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 homulanon 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an has autopsy page 2 D No 1 □Yes After this certification, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manne Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Hospital or Attending 1 Uf atural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. reral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Homicide within 24 hours a To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cahon Meeraja 900 31. Date filed (Month, Day, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 28 2009 00:21 A M Februa н. Hove] /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Rosedale Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 □ F Director 217-16-3167 April 23, 1924 Germany Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 XNo 28a-f Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? ö 23a 425 Torner Road Funeral 21221 S. Α. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: ģ 3 Widowed 4 Divorced "natural" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withir ment of Health and Mental Hygiene. ant: If item 27 Is marked other than 5 Steel Worker Steel Mill Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည William Sommers Hovel Louise 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 Is
any injury or other trau Carolyn M. Hovel Essex, Mary and 21221 425 Torner Road Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 3, 2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Marvland Meadowridge Mem. Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 uchou 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Fatal Archythmia /Medical Due to (or as a consequence of): Examiner Lyocardia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed physician and s the buriat-trans aronary Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. ed by the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed/ 1 Yes 2 No certificate 1 ☐Yes 2 ☐No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Records, Hospital or Attending Physician; The of Vital Division within 24 hours after death

To the Funeral Director:
completely filled in by the To the within 2

> State Registrar

DHMH 17 Rev 1/200

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

Dr. Johnathan

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hansen

32. Registrar's Signature Serve S. pare

2000 Franklin

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

(e1310

Square Drive Boltimore MD, 26237

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 9 06325 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Feb. Day 2009 **Physician** 3:25 AM William R. Haugh, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Carroll Hospice-Dove House 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** XIXM 2□ F Months Days Hours 79 Director 214-28-5051 1/16/1930 MD Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 28a-f show r than "natural", or items 23a or 28a-f shov 1 □Yes ŽŽNo Director MD Howard Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21797 USA 16324 A.E. Mullinix Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 1951–53 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status and 2 should be filed within 72 hours after ealth and Mental Hygiene.
n 27 is marked other than "natural", or ite, or traumatic event. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Š 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) R.H. Mullinix Truck Driver/Farm Laborer permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othr any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William R. Haugh, Sr. Ethel Mae Day 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Mae Haugh/Wife 16324 A.E. Mullinix Rd., Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State South Carroll Crematory 2/24/09 4 ☐ Donation 5 ☐ Other (Specify) Winfield, MD 22. Name and Address of Facility 21. Signature of Funeral Service L Burrier-Queen Funeral Home & CrematoryPA 1212 W. Old Liberty Road Winfield Maryland 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 7/18/08/00 2/24 /Medical Due to (or as a consequence of): Examiner perut Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and -tran Due to (or as a consequence of): physician a s the burial-1 Box 68760. Physician/Medical attending philon at the IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Ö the a 9 Unknown 9 Unknown ģ Ф. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 1 ☐ Ves 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed certificate 2 **UN**O 1 □Yes 2 □ Mo 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Dove Here Vithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral direction. 1 Tyes 2 DNd 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

34

State Registrar ate filed (Month, Day, Year)

MAR 0 3 2009

32. Registrar's Signature

d cause of death (Item 23a) (Type, Print)

DO064162

fa. Street (ASTUNDSTER MD 2115)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February **Physician** MEREDITH HILLIARD 2009 8:20 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Pickett Road Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept 27, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1 M 2 □ F 1924 Maryland 84 219-16-9564 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examilian is ust be notified at 1 ☐ Yes 2 ☑ No Director Delaware Sussex Selbyville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 19975 USA 36 Grant Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 2 □ No 1 ☐ Yes 2 💆 No Specify: White þ Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Architect Commercial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie O'Neill John M. Hilliard, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health & Important: If item 27 is any Injury or other traus once. Mrs Holly Grinnell/ Daughter 7 Pickett Rd. Lutherville, Md. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place)
Hilltop Service Co. 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 3-3-09 Towson, Md. 4 Donation 5 ☐ Other (Specify) 21. Sign 22 Ruck of tows of actioneral Home, 1050 York Rd. Towson, Md. ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or com shock, or heart failure. List only or complica Metastatic Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a ponsequence of Examiner If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): physician sthe burial Physician/Medical attending properties for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Tes 2. No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 24a. Was an cate has l page 2 s autopsy perform certificate 1 ☐ Yes 2 2100 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify Residence 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

law requires that the death certificate P.O. Division of Vital Records, Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificaletely filled in by the funeral director, p. within 2.

be executed

Box 68760,

Baltimore, Maryland 21215-0036

10+1

31. Date filed (Month; Day, Year) State

29b. Signature and title of certifier

30. Name and address of person who completed clause of death (Item 23a) (Type, Print)
Dr. Robert Donegan 6,569 North Charles St. Suite 205 Towson, Md. 21204

Registrar

29c. License number

D0056919

29d. Date signed (Month, Day, Year)

2/27/09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 2, ^D2009 Year 3:10 A Thelma H. Hunter 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 3 Parkville Oakcrest Care Center If Under 1 Year _ If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Hours Months Days 3/1/1920 Maryland 213-18-7142 89 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location MD 1 ☐ Yes 2 X No Parkville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21234 8832 Walther Blvd Apt 233 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 No Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Grace F. Armstrong Howard E. Harrison, Sr. 19a. Informant's Name/Relationship (Type. Print) Joseph E. Hunter / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Lookout Ct. Gettysburg, PA 17325 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1) Burial 2 ☐ Cremation 3 ☐ Removal from State 3/5/2009 Dulaney Valley Mem. Timonium, Maryland 4 Donation 5 Other (Specify) Maryland 21204 Inc. 1050 York Road 22. Name and Address of Facility Towson, Ruck Towson Funeral Home, 21. Signature of Funeral Service Lie 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End pulmonany nuperlension stage Due to (or as a considence of: valvular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☑No 9 Linknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. abillat 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☑No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Examine Hospital or Attending Physician: The law requires that the death certificate be executed thus after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit Records, P.O. Box 68760, ✓ certificate has been signed by the rector, page 2 should be detached Division of Vital 24 hours a

Physician

/Medical

Examiner

Funeral Director

Be Completed by

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examiliant must be usefulfied at any injury or other traumatic event, If a Medical Examiliant in the statement of once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Physician/Medical 2 Be Completed Medical Certification: To

4 Homicide 29a. Certifier (Check only one)

3 Suicide

5 Pending investigation

6 ☐ Could not be

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 3/2/04

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

and manner stated.

State Registrar



within 24 hou To the Fune completely fi

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		-	For State Registrar	State of Maryland		artmen <i>tificate</i>			and Me		iene g. No. 2	009	06	328	
	hysicia /Medic		1. Decedent's Name (First, Middle, Last)		. /	ywa		,	1	2. Date of Death Month Februar	Day .	Year 2009	3. Time o 4:56		
	Examin	er	4a. Facility Name (If not institution, give state) The Johns Hopkins Ho 5. Social Security Number 6. Sex	spital	ast hirthday)	4b. City, Baltir If Under	nore	City If Under		8. Date of Birth	4c. Cour	N/A	place (State o	or Foreign	
Dir	neral ector	-		м 2□	Yrs.	Months	Days	Hours	Min.	(Month, Day, 12-10-	Year) 62	PA	try)	n i dioign	
e Maryland	Ba-f show	Director	10a. State 10b. County N/A		imore							1	10d. Inside C	City Limits 2 □ No	
ath with th	s 23a or 2 ust be no		10e. Street and Number 3028 Gilford A	venue			218				ig. Citizen o	f What Coun	try?		
, Maryland 21215-0036 and 2 should be filed within 72 hours after death with the Maryland saith and Mental Hygiene.	If item 27 is marked other than "hatural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by Funeral	1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes, 2 ₹ No If Yes, Give Year or Dates:	1	I □ Yes 2	2X No	Specify:	gin? (Spec , Puerto Ri	ify Yes or No- can, etc.)	Spec	ace-Americ lack, White, Afri Ameri	can		
d 21215-0036 filed within 72 hours aft Hygiene.	r than "nati the Medica	Completed	15. Decedent's Edu (Specify only highest gradi Elementary/Secondary (0-12)		16a. Deced (Give life. L Cust	kind of wor DO NOT us	rk done d e retired)	uring most		g	Medi	Business/Ind	dustry		
Baltimore, Maryland of permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg	marked othe	To Be C	17. Father's Name (First, Middle, Last) Russell L. Hay					Ма	ggie	(First, Middle, M L. La	wren	ce			
and 2 sho ealth and	n 27 is m ner trauma		19a. Informant's Name/Relationship (Tyr Ternilia Myers	/Sister	1425	Ind	epe		ce C	Route Number, t, Leav	ren W	orth,	KS660	048	
Baltimore, Mi permit. Pages 1 and 2 Department of Health a	ant; If itel jury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 3 Other (Specify)	lemoval from State Ba	lace of Dispo emetery, cren YView	natory or ot Cre	ther place mat o	ory	3/4/	09 B	alt.	•			
Baltimo	Important; any Injury once,		21. Signature of Fundral Service License		5	126	Bela	air]	Rd,B	P. Cl alt.,M	D 21	F. Sv 206-5	105		
	ician dical niner		23a. Part 1. Entir the dise as a compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Lutra Cua Due to (or as a consequ	anial					respiratory arre	st,		Approximation Interval Bet Onset and	tween	
8760, cate be executed	physician and the burial-transit	edical Examiner		Sequentially list conditions, and a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ					-					
	are nas been signed by the attending phys page 2 should be detached for use as the	Ž	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		☐ Ectopic pregnancy ☐ Other (specify)					23d. Date of delivery Month Day Year					
ds, P.O.	signed by	by	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderlying o	cause give	en in Part I	l.	23e. Did tob		ontribute to th		death? Unknown	
Recol	page 2 shou	Completed	Lymphoma		•					24a. Was an autopsy perform		o. Were autoprior to condeath?	mpletion of	available cause of	
/ita	rector, pa		25. Was case referred to medical examiner?	la a sitati					of Death (0	Check only one					
of of	al dire	욘	1 ☐ Yes 2 ☑ No 27. Manger of Death	lospital: 1 1 Inpatient 2 1 2 28a. Date of Injury	ER/Outpatient 28b. Time of			4 🗆 Nur		5 Resider)		
Division of Vital Records, To the Hospital or Attending Physician: The law requires the within 24 hours after death.	o the runeral bractor: Affer fins certifies completely filled in by the funeral director,	Certification:	1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year) 28e. Place of injury - At hor building, etc. (Specify)	Injury ne, farm, stre	м	_	at es 2 🗆 N	10	d. Describe how if. Location (Str. City or Town,	eet and Nur		l Route Nun	nber,	
ie Hospital	pletely filled		29a. Certifier 1 CertifyIng Physics (check only one) 2 Medical Examin	sician: To the best of my knowner: On the basis of examinati and manner stated.	fledge, death on and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deal	d place, an	nd due to the ca	use(s) and ate and plac	manner as st e, and due to	ated. the cause((s)	
To the	n of	Me	29b. Signature and title of certifier	il.			License RE		000		d. Date sign	ed (Month, E	Oay, Year)		
H	\checkmark		30. Name and address of person who co	Tabibian		Print)			600 N	orth Wolf	e St, B	altimor	e, MD,	21287	
	Stat Registra	G	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ne 2										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year 536 A M February 23 2009 Ic. County of Death **Physician** Ones ratricia /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A**Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Ye. June 22, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) Year) Days **Funeral** 1 🗆 M 2 🗓 F 66 Yrs 1942 Pennsylvania 181-34-6568 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State or 28a-f show 1 ☐ Yes 2 X No Examiner must be notified at Directo Ellicott City Maryland Howard 10g. Citizen of What Country? 10e. Street and Number USA 21042 items 23a 11433 Butterfruit Way Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes ZX No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. specify: Black 'natural", or þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical College (1-4 or 5+) 5+ Elementary/Secondary (0-12) and Mental Hygiene. is marked other than Social Services Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNK Marjorie Lee ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other trau once. 11433 Butterfruit Way Ellicott City, Maryland 21042 J. <u>Pendleton Jones, Husband</u> Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 anent of He 20a Method of Disposition Metro Crematory Inc. 02/26/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee
Thomas Gregor permit. Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Mult **Physician** Stem organ disease or condition resulting in death) Due to (or as a con equence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of The law requires that the death certificate be executed that initiated events attending physician and I for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day ed by the attent in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2X No 3 ☐ Probably 4 ☐ Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 💢 Yes 2 No 2 🗌 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 🗆 DOA Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient P . Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 5 Pending investigation Injury 1 Natural 2 Accident 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: thin 24 hours after death.

the Funeral Director: Aft
ompletely filled in by the fu To the I within 2

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 23, 2009 RES-000 30. Name and address of pers a win completed cause of death (Item 23a) (Type, Print)

TRAN

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last **Physician** /Medical County of Death Examiner Baltimo Year) (In yrs. last birthday) If Under Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Director Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" any injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10a State Yes 2 □ No Funeral Director 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 12. 11. Marital Status 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) condary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) ပ္ 19b. Mailing Address (Street and Number or Pura Place of Disposition (Name of cemetery, crematory or other p 20c. Location 20a. Method of Disposition 1 Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a detached f 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown is certificate has been s director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2700 Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 564 0 0

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

0.3 2009

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Reg. No.20 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 6130 PM DOLORES M. KABLE **Physician** 2009 01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie Anne Arundel 938 Genine Court | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1-13-1932 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F MD 216-28-8006 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10b. County 10a State ir than "natural", or Items 23a or 28a-f show It a Medical Examiner must be motified at 1 ☐ Yes 2 X No Glen Burnie MD Anne Arundel Completed by Funeral Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number TISA 21060 938 Genine Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Visa College (1-4or 5+) Elementary/Secondary (0-12) PBX Operator permit. Pages 1 and 2 should be filed v Deportment of Health and Mental Hygie. Important: if Item 27 is marked other th any injury or other traumatic event, ILA ODGE. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) To Be Philomena Burkhart Danie1 Rice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 938 Genine Crt, Glen Burnie MD 21060 Mrs Nancy Kneisly/daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2/6/09 Baltimore MD Holy Redeemer Cemetery 5 Other (Specify) 4 Donation 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA 421 Crain Hwy SE Glen Burnie MD 21061 M01364 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enspycene **Physician** Enditore disease or condition resulting in death) /Medical Due to (or as a copsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Chief to [or as a consequence of] Examiner physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown DROMARY ARTERY DISENSE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Ho MEHITUS AF TES 24a. Was an performed' VASCULAR DIEASE CERIPHERAL 2 - No 1 ☐ Yes Attending Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 nesidence 6 Other (Specify) 2 1 Yes 2 10 To the Hoepital or Attending Phys within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral di 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Curtifying Physicians: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29h Signature and title of certifier 03/03/2009 055506 Retiettighing Paretere Maylow 21/22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8109 31. Date filed (Month, Day, Year) State MAR 0 3 2009 Registrar

		-	For State Registrar	State of Marylar		artment of F ctificate of			Reg. No. 2	09	06332
	Physicia	an	Decedent's Name (First, Middle, Last)	K u Co l	2 - 1 - 1			2. Date of Dea Month	ath Day	Year 09	3. Time of Death
and a second	/Medic	al	4a. Facility Name (If not institution, give si	K U ra V		4b. City, Town, o	r Location of Deat		27 4c. County		00107(111
	Examin		Johns Hopkins Bay			ball	If Under 24 Hrs.			O Diethe	Ness (Ctate or Enroign
	Funeral Director		5. Social Security Number 6. Sex 1□	7. Age (In yrs	2 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da March 6	y, Yea <i>r</i>) , 1926	Cour	place (State or Foreign htry)
	and wo		Usual Residence of Decedent 10a. State 10b. County	10c. C	lity, Town or Lo	cation				1	0d. Inside City Limits
	a-fsho	ctor	MD Baltimo:	re		Middle	River				1 □ Yes 2 XNo
	vith the	Funeral Director	10e. Street and Number	D 3		10f. Zip Code	200		10g. Citizen of Gre		ntry?
	death v	neral	6902 Columbia 1	2. Was Decedent Ever in U	J.S. 13.	Was Decedent of H	∠∠ U Hispanic Origin? (San, Mexican, Puer) Alice Service A	Specify Yes or No		ce - Americ	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite involces Examination in a collised at once.	by Fu	1 ☐ Never Married 2 ☐ Married ★★Widowed 4 ☐ Divorced	Armed Forces? 1		1 ∐Yes 2XX No		to moan, etc.)	Specif		ite
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121	within ene.	dmc	Elementary/Secondary (0-12) 5th	College (1-4or 5+)	Coc	_	d)		Foo	d	
ک ام	e filed al Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle,		ne)	
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ore,	ss 1 ar of Hea fitem ? r other		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other pla	ce)	Date	20c. Location		
<u>ii</u>	t. Page tment tant: It ijury o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)	0			ery 3/2		Balti		
	permii Depar Impor any ir once.		21. Signature of Tuneral Service License	Connelly		Connell Connell	y Funer	al Home	e of E	Balt ssex	imore MD 21221
			23a. Part 1. Enter the disease, or comples shock, or heart failure. List only on	e cause on each line.	ath. Do not en	ter the mode of dy	ing, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
Tage .	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or s a conse	wer h	there	ailure			- 1	3 manths
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	Si ec	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	equence of):					Į	
ď.	ificate be executed physician and is the burial-transi	Examiner	that initiated events c resulting in death) Last	Due to (or as a conse	equence of):						
68760,	ate be hysicie the bur	edical	d								
			IF FEMALE: 23b, Was decedent pregnant	3c. If yes, outcome of preg					23d. Da	ate of deliv	ery
O. Box	law requires that the death cert as been signed by the attendin; 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown		☐ Ectopic pregnan☐ Other (specify) _	cy		М	onth	Day Year
٠ <u>.</u>	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions con	tributing to death but not re	esulting in the L	inderlying cause gi	ven in Part I.	23e. Did t	obacco use cor	tribute to t	he cause of death?
ords	equires sen sig ould be	led b	Amalobr	maron				1 🗆	Yes PI No	3□ Pro	bably 4 🗌 Unknown
3ec	e law r has be je 2 sh	Completed	Kbility					24a. Was auto perfo	psy ormed2	prior to co death?	opsy findings available ompletion of cause of
tal	ician: The lav certificate has ector, page 2:	l ou	25. Was case referred to medical				26. Place of De	1 ☐ Yes	2 No	1 🗆 Yes	2 No
Į Vi	hysici his cer I direct	To B	examiner? 1 ☐ Yes No	lospital: 1 🗆 Inpatient 2		nt 3 🗆 DOA		Home 5 ☐ Resi			ify)
o uc	ding P h. After t funera	ion:	27. Manner of Death 1 Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wo	uryat ork?]Yes 2 □ No	28d. Describe	how injury occu	rred	
Division of Vital Records,	r Attenter deatlinector:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st ecify)				Street and Num wn, State)	ber or Rur	al Route Number,
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Medical Ce	29a. Certifier Check only one) 2 Medicai Exami	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, dea ination and/or i	th occurred at the nvestigation, in my	time, date and place opinion, death occ	ce, and due to the curred at the time	e cause(s) and r , date and place	nanner as , and due t	stated. to the cause(s)
	To the within To the comple	Mec	29b. Signature and title of certifler	n . ka . "	1		nse number		29d. Date sign	- 1	20
			Hyrsey	way u.	J	DU	7484		2/2	110	/4
			30. Name and address of person who co	impleted cause of death (It	tem 23a) (Type	Print)	nuiw	and	Balm	ove	MD 2122
	Sta	ate	31. Date filed (Month, Day, Year)	3. Registrar's Sig	ina ire	Mal				/	

State Registrar

MAR 0 3 2009

Physician /Medical

Examiner

Be Completed by Funeral Director

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Examiner

Funeral

Director

Registrar	Certificate of Death	Reg. No.	6333
Decedent's Name (First, Middle, Last)		Adamshi Davi Vana	ne of Death
William F. Komber		2 27 200 9 11	05 A M
. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		
FRANKLIN SQUARE HOSPITAL C		Baltimor	
Social Security Number 6. Sex 7. Age (In yr 217-40-3193	rs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (S Country)	tate or Foreign MD
sual Residence of Decedent	64 Yrs.	000.24,1944	MD
Da. State 10b. County 10c. (City, Town or Location	10d. Insi	de City Limits
MD Baltimore	Essex	1	Yes 21 No
e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
815 Brunswick Road	21221	USA	
. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.) 14. Race - American India Black, White, etc.	an,
1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	1 ∐Yes 2 X No Specify:	Specify: White	3
3 ☐ Widowed 4 ☐ Divorced Year or Dates:	16a. Decedent's Usual Occupation	16b. Kind of Business/Industry	
15. Decedent's Education (Specify only highest grade completed)	(Give kind of work done during most of work life. DO NOT use retired)	king Rind of Business/industry	
Elementary/Secondary (0-12) College (1-4or 5+)	Custodian	Baltimore Cou	ınty
7. Father's Name (First, Middle, Last)	18. Mother's Nar	ne (First, Middle, Maiden Surname)	
Frederick H. Komber	Agnes	Peterson	
9a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Re	ıral Route Number, City or Town, State, Zip Code)	
Doris Canatella /sister	412 Katherine Ave	enue Baltimore MD 21	1221
4 T 5 14 0 T 0	o. Place of Disposition (Name of cemetery, crematory or other place) ayview Crematory 2/2	Date 20c. Location - City or Town, Sta 28/09 Baltimore MI	
1. Signature of Funeral Service Licensee	Connelly Fune	00 Mace Ave. Balto. cal Home of Essex 21	1221
23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. mmediate Cause (Final	eath. Do not enter the mode of dying, such as cardia	Interva	ximate al Between and Death
disease or condition a. Se si sesulting in death)			
. multisu	istem organ fail	ure	
equentially list conditions, ause. Enter Underlying	equence of):		
Cause (Disease or injury hat initiated events c. Pas Teure			
esulting in death) Last Due to (or as a cons	sequence of):		
d			
F FEMALE:			
3b. Was decedent pregnant in the past 12 months?	etal death 3 Ectopic pregnancy	23d. Date of delivery Month Day	Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	of death 5 Other (specify)		
art II. Other significant conditions contributing to death but not r	resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the caus	e of death?
	3	1 ☐ Yes 2 ☐ No 3 ☐ Probably	4 Unknowr
		240 Was an 24h Was out	dings available
		24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy fine prior to completio death? 1 □ Yes 2 □ No	n of cause of
5. Was case referred to medical	26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2	□ ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 Residence 6 □Other (Specify)	
1 Impatient 2		20st Departure house informations and	
17. Manner of Death 1	r) 28b. Time of lnjury 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurred	

Medical Certification: To Be Completed by Physician/Medical

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran

> State Registrar

DR A Day Better 1 31. Date filed (Month, Day, Year) MAR 0 3 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

Square DR Balto

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

64408

29d. Date signed (Month, Day, Year)

21237

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md

AZ یو 11 2009 February 25 Baltimore, Maryland 21215-0036 Virginia Keyes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a Pestate of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) D 25 2009 **Physician** February 11:46 a M Virginia L. Keyes /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Timonium 2525 Pot Spring Rd. #311 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 1 F 85 May 9, Maryland 218-12-2342 1923 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County show ral", or items 23a or 28a-f shore Examiner must be notified at 1 ☐Yes 2 🕱 No Director Timonium Md. Baltimore 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 USA 2525 Pot Spring Rd. #311 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🕱 No 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Specify Specify: White 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Maone. Elementary/Secondary (0-12) Professor College 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Naomi Tracy Charles Vayne ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4105 Alachua Ave. Titusville, Fl. 32796 Mrs. Carol Vayne/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition + Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 3-4-09 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service Lid Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician Arterioschnotic /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to (or as a consequence of) Examine Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ∐Yes 2 XNo 2 X No 1 □Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27, Manner of Death After 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director; A completely filled in by the ft 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

mble Hill CT. Luther ville Md Z1092

eted cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 26, 2009 **Physician** 2:55 A M Nancy K. Kraus /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Presbyterian Home of Maryland Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours 1 □ M 2 🔀 F 88 November 13, 1920 Missouri 487-20-8714 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mential Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be well as any injury or other traumatic event, the Medical Examiner must be well as 1 ☐ Yes 2 X No Director **Baltimore** Towson Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21204 USA 400 Georgia Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther Mae Mull Charles Henry Kelbaugh ပ္ 19a. Informant's Name/Relationship (Type. Print)
Robert P. Kraus / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Westway Court, Rochester, New York 14624 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ *Cremation 3 ☐ Removal from State Hillton Service Corp 2/28/2009 Towson, Maryland 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eacl, line. Approximate Interval Between Onset and Death Immediate Cause (Final nehmo mis **Physician** week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and A attending physician and for use as the burial-transit pe execu Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 🖾 No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. acc. Ile 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐Yes 2 Ho To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide TCCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MP - Attending 26, 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Green, ms 6701 N. Charles St / Sente 4104 Balthur, Leaneth M. 31. Date filed (Month Day, Year) egistrar's Signature Registrar

1. Decedent's Name (First, Middle, Last) **Physician** /Medical Examiner **Funeral** Director

Perint. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" any injury or other traumatic events.

Physician /Medical

Examiner The law requires that the death certificate be executed physician and s the bunial-trans Division or Vital Records, P.O. Box 68760. for use e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica completely filled in by the To the I within 2.

FEBRUARY 25 2009 11:15 PM MARGARET KAUFMAN 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death LEVINDALE HEBREW HOME BALTIMORE 8. Date of Birth (Month, Day, Year, 10/11/1916 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Days 1 □ M 2 🛚 F 92 CA 215-10-7101 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 □ No **Funeral Director** BALTIMORE MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2434 W. BELVEDERE AVENUE 21215 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No WHITE Specify: Be Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) PAPER PRODUCTS OWNER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **PARELHOFF** RACHEL MENDELSON MORRIS ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 51 IRONWOOD CIRCLE, BALTIMORE, MD FRANK KAUFMAN / SON 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HEBREW FRIENDSHIP 02/27/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) month Chinjiama Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 tailure 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performs 2 No 2 No 1□ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Soursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ 27. Manner of Doth 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident (Month, Day Year) Injury 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide trifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) tine of certif 29b. Signature a completed cause of death (Item 23a) (Type, Print) 30. Name 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

3. Time of Death

DHMH 17 Rev 1/2001

Registrar

0 2 2009

		For State	State of M		Эера	rtment of H	lealth and l	Mental Hyg	giene	09	06337
		Registrar 1. Decedent's Name (First, Middle	Last)					2. Date of Dea			3. Time of Death
Physic	ian							Month Februar	y 10,	Year 2009	7:15 PM M
/Medi		Mary Gertrude				4b. City, Town, or	Location of Deatl		-	ity of Death	
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/		3911 Chesley A		ge (In yrs. last bir	rthdav)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	9. Birth	place (State or Foreign
Funeral Director		217-24-2663	1 □ M 2 🖫 F		Yrs.	Months Days	Hours Min.	Apr 21,	1928	Mar	yland
		Usual Residence of Decedent		- 00				, ,			
/land		10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits
Man Ff st	ig	MD		Ва	alti	more					1 Yes 2 □ No
r 28%	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	of What Cou	intry?
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deat	Funeral	11. Marital Status	12. Was Decedent	t Ever in U.S.	13.	Was Decedent of H	ispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. R	ace - Amer lack, White,	
or ite		1 ☐ Never Married 2 💢 Marri				1∐Yes 2X∏No	Specify:	,		eify: wh	
72 hours after death with the Maryland returnal", or items 23a or 28a-f show dient Examirer must by retified at	d by	3 Widowed 4 Divorced	Year or Dates:							·	
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2 should be filed within and Mental Hygiene. Is marked other than 'raumatic event, It of the standard other 'r	은			1 4 84	B. 6 - 12					vn Stata 7	in Codo)
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T and t and Health em 27		James Lochary/	spouse					Date	20c. Locatio		
Pages 1 nent of h int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from State	e cemete	ery, crei	sition (Name of matory or other plac	ce)				,
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- GD - 60	1	semy	1 East	addies de alle Do	Ba	altimore,	MD 212	01	reet		Approximate
		23a. Part Enter the disease, or shock, or heart failure. List	only one cause on each	ed the death. Do line.	not en	cer the mode of dyll	0		rest,		Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	_a. Med	tastati	c	Colon	Cance	X		1	2 40ars
/Medical Examiner		resulting in death)	Due to (or a	as a consequence	of):						•
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eath cel attendii	cia	23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Fetal deat t at time of death		☐ Ectopic pregnand ☐ Other <i>(sp</i> ec <i>ify)</i> _	су			Month	Day Year
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that led by deta		Part II. Other significant condition	ons contributing to death	but not resulting	in the u	ınderlying cause giv	en in Part I.	23e. Did to	obacco use c	ontribute to	the cause of death?
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n: The		25. Was case referred to medica	1				26 Place of De	1 ☐ Yes eath (Check only o	2 No	1 Li Yes	2 □ No
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ding Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	5	27. Manner of Death	28a. Date of Ir	njury 28b.	Time	of 28c. Inju	ry at	28d. Describe			y)
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DIVISION or Attending after death. Director: After din by the function	ertification:	3 ☐ Suicide 6 ☐ Could	Zoe. Flace of I	Injury - At home, f	farm, st	reet, factory, office		28f. Location (ımber or Ru	ıral Route Number,
affer Dire	ert	4 ☐ Homicide determ	building,	etc. (Specify)				City of 70	wii, State)		
spita nours nera y fille	aC	29a. Certifier 1 Certifyi	ng Physician: To the be	st of my knowled	ge, dea	th occurred at the t	ime, date and pla	ce, and due to the	cause(s) and	d manner as	s stated.
UNISION OF VITAL MECOLDS, P. O. DUX OOR To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	ledical	(Check only 2 Medical one)	Examiner: On the basis and manner	s of examination a stated.	and/or i	rivestigation, in my	opinion, death occ	ourieu at the time,	uate and pia	ce, and ade	to the cause(s)
To the To the To the To the Comp	Me	29b. Signature and title of certifie	50 h			29c. Licen	se number		29d. Date sig	gned (Monti	h, Day, Year)
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		30. Name and address of person	who completed cause o	of death (Item 23a) (Type	, Print)	N	1.			
		Charles ladget	, and ,56	or Lock	Ka	ven Blud	L, Kal	timore,	My :	21230	1
	State	31. Date filed (Month, Day, Year,	nng \$2. Regi	strar's Signature	40	, Print) ven Blud					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Baby Boy Lau /Medical 02 2009 6 = 16AM 26 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs Hours Min. Social Security Number 6 Sev Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Birthplace (State or Foreign Country) 1 💢 M 2 🗆 F Months **Director** infant 49 Feb 26, 2009 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Anne Arundel Severn 1 Yes 2 No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1260 Colonial Park Drive Items 23a 21144 Funeral USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1X Never Married 2 Married Black, White, etc Baltimore, Maryland 21215-0036 ō þ 1 Yes 2X No Specify: 3 Widowed 4 Divorced Specify: asian "natural", Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) infant infant infant Pages 1 and 2 should be filed in nent of Health and Mental Hygic int: If item 27 is marked other infant 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Jay Sun 2 Michelle Lau 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The John Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 21287 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Pages
Department of the Important: If ite any Injury or ot 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5 NOther (Specify) in state 4 Donation 21. Signature of Funeral Service Ronal of ce Licensee Wirector State Anatomy Board 655 W. Baltimore Street m Baltimore, MD Par 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Pan Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Day Pregnant at time of death Month 1 Yes 2 No Year 5 Other (specify) the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 1 Tes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 4 \(\sum \) Nursing Home ၉ Inpatient | 2 ER/Outpatient 3 DOA After this 5 Residence 6 Other (Specify) Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident 1 Yes 2 No within 24 hours after deat To the Funeral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital or A within 24 hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) State MAR 0 3 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieme (1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ye ar **Physician** 02 2009 Anna Lozos /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Franklin Square Hospital
5. Social Security Number 6. Sex 7. Ac Baltimore Center Rosedale 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
September 22,1918 Pennsylvania 7. Age (In yrs. last birthday) If Und **Funeral** Days Months 1 □ M 2 🗓 F 90 Director 209-09-8986 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "doal Experience and injury or other traumatic event, the "doal Experience and once." 10a. State 10b. County 1 ☐Yes 2☐No Directo Perry Hall Balto. Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21236 3825 Proctor Lane Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) General Office <u>Secretary</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Petroula Slkavunu 2 Christos Lambrou 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3825 Proctor Lane Perry Hall, Md. 21236 Son George Lozos 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 3-6-2009 Parkville, Md. Demetrios 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 9705 Belair Rd. Nottingham ,Md. 21236 De 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a Non ST Segment Myocardial Physician disease or condition resulting in death) /Medical Examiner Severe Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hypercholesterolemia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 1 □ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27, Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive, Novello MD Baltimore, MD 21237 Nona 31. Date filed (Month, Day, Year) State MAR 03 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day 24 FEBRUARY 2009 **Physician** 5:55 A M LYNCH CHRISTOPHER D. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNAPOLIS ANNE ARUNDEL BAYRIDGE NURSING HOME If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 1 1966 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 X M 2 1 WASHINGTON, DC 42 213-02-2120 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10a, State or items 23a or 28a-f show 1 Yes 2 □ No Director PRINCE GEORGE'S TEMPLE HILL MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20747 4401 23rd PARKWAY # Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Narried BLACK ٥ 21215-0036 1 ☐ Yes 2 No Specify. 2 3 Widowed 4 Divorced "natural" er than "natura , the Medical E Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE ROOFING FOREMAN 12th Department of Health and Mental Hygic Important; if item 27 is marked other any injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname, Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be NANCY ANN WILLIAMS WILLIE G. LYNCH ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1816 COPELAND STREET # D ANNAPOLIS, MARYLAND 21401 ARTIA HARPER-LYNCH/WIFE 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RIVERDALE, MARYLAND RIVERDALE CREMATORY 2/27/09 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FULERAL HOME 21. Signature of Funeral Service Ligenses 0 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final MULTIFOCKL Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine lor Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 Tyes 2 No 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No certificate 1 ☐Yes 2 ☑ No 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this nours after death.

neral Director: After this
filled in by the funeral d 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and profet drive, Ellicott city State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 24, 2009 **Physician** tebruary Liptak Alice /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie Baltimore-Washington Medical Center 8. Date of Birth (Month, Day, March 12, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 → F Days Hours Min. Mary Land 65 Director 212-40-0982 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "wideal Event and a ust be natified." 1 □Yes 2 No Director Anne Arundel Pasadena Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number U.S.A. 21122 1845 Cook Farm Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced 2 should be filed within 72 hours and Mental Hygiene. Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Anne Arundel County Schools Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ramev Dorothy Perry John မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1845 Cook Farm Court Pasadena, Maryland 21122 permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any Injury or other trau William E. Liptak (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 14 Burial 2 ☐ Cremation 3 ☐ Removal from State 02/27/09 Lakeview Cemetery Sykesville, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of): Examiner VI NIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

9 Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the humal-tranes. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 □Yes 2 ☑No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 11/10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manny of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Watural 1 ☐Yes 2 ☐No 2 Accident 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier within 24 hou To the Fune completely fi (Check only

State Registrar

15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Drive, Glen Bui 31. Date filed (Month, Day, 3 2009

29b. Signature and title of certifier

ho the MD

29c. License number D41365

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 00000 /Medical 4c. County of Death Facility Name (If not institution, give street Town, or Location of Death **Examiner** 8. Date of Birth Month, Day, **Funeral** Days Yrs. Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Madical Examinal must be notified at 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Married 1 Ses 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) rketing Execu 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SR | Macy Macy State, Zip Code)

19b. Mailing Address (Street and Number of Rural Route Number, City or Town State, Zip Code)

To mro Florida 34212 ဥ 19a. Informant's Name/Relationship (Type. Print) Florida 20c. Locat 20a. Method of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State Department o Important: If any injury or once. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death or as a consequence of): Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ue to Examiner Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE Division of Vital Records, P.O. Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) No No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient Medical Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA this funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of 1 Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 1 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ho completed cause of death State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 9:43 PM ewis - Roberson Barbara Feb 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner niversity of Maryland Medical Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2▼F Months Days Hours 212-46-5069 Usual Residence of Decedent Director with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Modical Examiner must be rediffed at once. 1 Xes 2 □ No Completed by Funeral Director 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 4 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. 20b. Place of Disposition (Name of cemetery, crematory or other Method of I isposition Burial 2 Cremation 3 Removal from State Donation Other (Specify) eral Service 21. Signature of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumenia /Medical Due to (or as a consequence of): Examiner leta-static adenocurcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 3 Ectopic pregnancy Year 5 Other (specify) Division of Vital Records, P.O. ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 XNo 1 ☐Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭KNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural ours after death. 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Feb 25 2009

Registrar

State

Greene

Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kristi

31. Date filed (Month, Day, Year)

22 S

2. Registrar's Signature

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 28, 2009 Physician February 7:06 A. M George S. Lopez /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/ABaltimore 3838 Roland Avenue Apt. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | May 4, 1926 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** XXM 2 F Maryland 213-20-7753 82 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Exx...inhr...unal be pufflished... once. XXYes 2 □ No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e, Street and Number USA 21211 3838 Roland Avenue Apt. 711 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 120 No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married Married Baltimore, Maryland 21215-0036 1 □Yes ŽŽNo White Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Unknown College (1-4or 5+) Noxell Corporation Mailroom Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Powers Stanley G. Lopez ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3838 Roland Avenue, Apt 711 Baltimore, MD 21211 19a. Informant's Name/Relationship (Type. Print) Wife Doris M. Lopez Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State Glen Burnie, Maryland Atlantic Crematory 3/2/2009 4 ☐ Donation (\$ ☐ Other (Specify) 22. Name and Address of Facility. Burgee-Henss-Seitz Funeral Home, Inc. 21211 21. Signature of Funeral Service Licens 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Minute Physician Mystardeal /Medical Due to (or d a consequence of): Examiner Antironlewte Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last g physician and s the burial-transit wester Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical tomen attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate ! 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending after death.

I Director: Af 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00026 394 D mall 21204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6535 NI CHARLET STAYSU WEGLEINI MD DONALD 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink.

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it in black indelible ink. Ensure All Copies Are Legible.	_	-	0		_
aryland / Department of Health and Mental Hygiene 2009	U	6	3	4	J

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	1. Decedent's
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Certificate of Death

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Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Marical Examination to notified at agree.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

5+1 State Registrar

	Registrar		uncate of L	Jeani		Reg. No.				
an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath Day Ye	3. Time of Death			
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er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death 4c. County of Death							
	Edenwald		Towson	If Under 24 Ure		Baltimo				
	1 40 4 20 6	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	y, Year)	Birthplace (State or Foreign Country)			
	219–20–8775 X V Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	86 Yrs.			July 15	, 1922 I	Maryland			
	10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits			
ō	Md. Baltimore	Towson					1 ∐ Yes 2 ☑ No			
rec	10e. Street and Number	TOWSOIT	10f. Zip Code			10g. Citizen of What Country?				
	800 Southerly Rd. #1106			1286		USA				
Jera	11. Marital Status 12. Was Decedent I	Ever in U.S. 13. V			Specify Yes or No		JSA merican Indian,			
Ē	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ N	40	Vas Decedent of Hi f Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	Black, W				
ğ	3 ☑ Widowed 4 ☐ Divorced If Ýes, Give Year or Dates:	1	□Yes 2√No	Specify:		Specify:	White			
Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa	ation	utria a	16b. Kind of Busine	ess/Industry			
np le	Elementary/Secondary (0-12) College (1-4or 5	+)	kind of work done a OO NOT use retired		King					
Š	5+	Gene	ral Surge	eon		Medical				
Be	17. Father's Name (First, Middle, Last)					Maiden Sumame)				
ပ္	Henry John Langenfelder			Kather	ine Lena	Beneze				
	19a. Informant's Name/Relationship (Type. Print)		-			er, City or Town, Stat				
	Mrs. Sue Shebel/ Daughter					tt City, M				
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place		Date	20c. Location - City	or Town, State			
	4☐Donation 5☐Other (Specify)	Druid Rid			-09	Pikesvi	11e, Md.			
	21. Signature of Funeral Service Licensee	22.	Name and Addres	wson Fur	neral Hor	me, Inc.				
	23a. Part 1. Enter the disease, or complications that caused	the death/ Do not ente	er the mode of dying	n Such as cardia	Cowson, I	Md. 21204 rrest.	Approximate			
2	shock, or heart failure. Lift only one cause on each lift immediate Cause (Final	ie. L. d	The same	C (10)		66.11	Interval Between Onset and Death			
	disease or condition resulting in death) a	2 JUGV	mac		MC BO	y Binau	en you			
	M. D. Color the observed									
Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of):	1 7 COM	uca	MAC	ase	3 701			
i E	Cause. Enter Underlying Cause (Disease or injury that initiated events c.									
EX	requiting in death I ant	a consequence of):								
Completed by Physician/Medical Examiner	d .									
Med	IF FEMALE:									
an/I	23b. Was decedent pregnant 23c. If yes, outcome	of pregnancy 2 Petal death 3 —	Ectopic pregnancy	,		23d. Date of				
sici	1 Yes 2 No 4 Pregnant a	t time of death 5	Other (specify)			Month	Day Year			
Phy	9 Li Unknown									
þ	Part II. Other significant conditions contributing to death but	at not resulting in the un	iderlying cause give	n in Part I.			e to the cause of death?			
ited		- 1			1 🗆 Y	es 20 No 3□	Probably 4 Unknown			
nple					24a. Was autop	an 24b. Were	autopsy findings available to completion of cause of			
Con					perfor	rmed? death 2 3 1 □ Y	1?			
Be	25. Was case referred to medical examiner?				ath (Check only o	ne)				
	1 Yes 20 No Hospital: 1 ☐ Inpatie			4 Ly Mursing F	lome 5 Resid	dence 6 Other (S	Specify)			
ion:	27. Manner of Death 1. Natural 5 ☐ Pending 28a. Date of Inju (Month, Da)	ry 28b. Time of Injury	28c. Injury Work		28d. Describe h	now injury occurred				
cat	2 Accident investigation 3 Suicide 6 Could not be 290 Place of Injury			res 2□No						
ertif	4 Homicide determined 28e. Place of Inju-	iry - At home, farm, stre c. (Specify)	et, factory, office		28f. Location (S City or Tow	Street and Number or in, State)	Rural Route Number,			
Medical Certification: To	29a. Certifier (Check only 2 Medical Examiner: On the basis of	of my knowledge, death	occurred at the tin	ne, date and place	e, and due to the	cause(s) and manne	r as stated.			
ledi	and manner sta	ited.								
2	29b. Signature and title of certifler	, /	29c. License	number		29d. Date signed (Mo	onth, Day, Year)			
	7/1	Noyth Com	~ 1	297	69	1/3	109			
	30. Name and address of person who completed cause of d			11	10 11	6 1 .	1 -2/2-2			
	21 Date filed (Month Day Very)		m) 51	6.1	Killin.	18/13	after by			
te	31. Date filed (Month, Day, Year) 32. Registra	ar's gnature	1		14	-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🤊 🖺 🤉 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** GERALDINE FRANCES 28, 4:05P M MALLON February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Presbyterian Home Of Maryland Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Jan 5,1925 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1□M 2√XF Days Director 032-12-9354 Massachusetts Usual Residence of Decedent 10a, State 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mydical Examiner is ust by notified at once. 1 □Yes 2 □ No Directo Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 400 Georgia Court USA 21204 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XX No Specify: \$ White Specify XX Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Personel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Aloysius McCarthy Mary Ellen Tobin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hugh Augustus Mallon III Son 601 Hawkshead Road Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Dulaney Valley Mem Gar Mar 5,2009 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facil Mitchell-Wiedefeld Funeral Home Inc signature of Funeral Service Licensee annis Dulaneni 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disence, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician archoma disease or condition resulting in death) one gear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No Day Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □ Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 SNursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 037016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Kenneth M. Green, ms

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

32. Registrar's Signature

670(N. Charles H., Sate 4104 Salthon, mo 21209

DHMH 17 Rev 1/2001

MARCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 0 0 9

		1	For State Ragistrar	State of Ma		epartment Certificate		nd Mental Hy	giene (09 0)6348
	Physicia	ın	1. Decedent's Name (First, Midd	dle, Last) 3ERT	MIC	orto		2. Date of De Month	eath Day Day	Year 2009	3. Time of Death
ſ	/Medic Examin		4a. Facility Name (If not instituti	ion, give street and number)			own, or Location of I	Death	4c. Cour	nty of Death	
			Hebrew Home of				ckville			tgomery	
	Funeral Director		5. Social Security Number	6. Sex 7. Age	e (In yrs. last birt 72	thday) If Under 1 Months		Min. 8. Date of Bi (Month, D June 2	rth ay, Year) 4, 1936	Country	ce (State or Foreign v) cida
	and w	- h	Usual Residence of Decedent 10a. State 10b. Count	ity	10c. City, Town	n or Location				10d	1. Inside City Limits
	f sho	ō	MD Monto	gomery	Rocky	ville					1 ☐ Yes 2XXNo
	the r	rect	10e. Street and Number	50		10f. Zip C	ode		10g. Cîtizen d	of What Country	y?
	h with	ai D	14610 #1 Bauer	r Drive			20853		U.S	6.A.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Madical Exactifier required any once.	by Fur	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 ሺሺvorce	If Yes, Give		13. Was Decede If Yes, specif		n? (Specify Yes or N Puerto Rican, etc.)		lace - American Black, White, etc cify: Whit	c.
2-0	72 ho	eted	15. Decede	lent's Education hest grade completed)	16a.	Decedent's Usual (Give kind of work	Occupation done during most of retired)	of working		Business/Indu	*
7	ithin ne.	Completed	Elementary/Secondary (0-12	College (1-4or 5	5+)	Architec			(VA)	Governm	ment
7	iled w tygiei thar ti		17. Father's Name (First, Middle	5 years		ALCIIILEC		s Name (First, Middle		name)	
anc	d be f	o Be	Giovanni Miot					a Rigutto			
Maryland	shoul nd Me mark marti	ဥ	19a. Informant's Name/Relation	onship (Type, Print)	19b	. Mailing Address (Street and Number	or Rural Route Numi	ber, City or Tov	vn, State, Zip C	Code)
	nd 2 satth at 27 is 27 is ir trau		Ginina Miotto	/ daughter	14	1610 #1 R	ockville,	Maryland	20853		
re,	is 1 a of Hea itam otha	- 3	20a. Method of Disposition	a Doministra State	20b. Place of cemeter	f Disposition (Name ry, crematory or oth	e of er place)	Date	20c. Locatio	on - City or Tow	n, State
E	Page nent c nnt: If ury or		1 ☐ Burial 2 ☒ Cremation 1 ☐ Donation 5 ☐ Other	on 3 Removal from State (Specify)		indel Cre		/4/2009	Odent	on, Mar	cyland
Baltimore,	permit. Departin Imports any inju		21. Signature of Funeral'S rvi		M00770	22. Name and Donlad 313 Ta	Address of Facility son Funer lbott Ave	al Home, enue Laur	P.A. el, Mar	yland	20707
25	Physician /Medical		23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	or complications that caused ist only one cause on each li a.	the death. Do no.	NOT enter the mode	SHRI T	HALLU	KE	li li	Approximate nterval Between Onset and Death
п	Examiner			ART A	a consequence	I'L H	YDER	TENSI	ON		
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence	of):					
	cuted Id ransit	Examine	that initiated events	1 c							
8760,	cate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as	a consequence	of):					
387	physi physi s the b	dicai		d							
.O. Box 6	at the death certific by the attending particles of the control of	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)							Date of delivery Month D	y Day Year
Δ.	s that t ned by e detai	by Ph	Part II. Other significant cond	ditions contributing to death t	out not resulting i	in the underlying ca	use given in Part I.	23e. Dio	tobacco use c	ontribute to the	cause of death?
rds	w requires been sign should be		SENI	LE UE	MEIN	1117		1	Yes 2D/No	o 3 ☐ Probat	bly 4 □Unknown
Records,	e lav has	Completed							opsy formed?	prior to comp death?	sy findings available pletion of cause of
Vital		O	25. Was case referred to med	fical			26. Place	of Death (Check only			
Į <	S S	To B	examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital: 1 ☐ Inpati	ent 2 ER/O			sing H <i>o</i> me 5 ☐ Re	sidence 6 🗆	Other (Specify)	
n of	ding Phy h. After thi funeral		27. Manner of Death 1 PNatural 5 □ Pen	28a. Date of Inju	ury 28b.		Bc. Injury at Work?		how injury oc	curred	
Siol	Attendir death. ctor: Al y the fu	cati	2 ☐ Accident inve	estigation		М	1 Yes 2 N		(Counce and Ale	umbarar Orumi	Cauta Alumbar
Division	or Attencater deatl Diractor:	Certification:		comince 200, Flace Ul III	jury - At home, I tc. (Specify)	arm, street, lactory,	office		own, State)	umber or Rural	noute Number,
	To the Hospital or Attending within 24 hours after death. To the Funatal Diractor: After completely filled in by the funer	ledical C	29a. Certifier 1 Certification (Check only 2 Medical Medical one)	ifying Physician: To the best cal Examiner: On the basis of and manner si	of examination at	e, death occurred a nd/or investigation,	it the time, date and in my opinion, death	I place, and due to the h occurred at the time	e cause(s) and e, date and plac	l manner as sta ce, and due to t	ited. the cause(s)
)	To the within 2 To the complet	M	29b. Signature and title of cert	and kee	berry	1 M.D.	License number D 35	436	FEBR	gned (Month, D. UARY	126, 2009 26, 2009 20853
¥			30 Name and address of pers	KANT LWY,		2/ MON	TROSER	POAD, ROL	CKVILL	E, MI	20853
		ate	31. Date filed (Month, Day, Ye		rar's Signature	41					
	Regist	rar	MAR 0320	109 Ceneral	p. 90	L/CC					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 25 **Physician** MILLS ELIZABETH 12:41 PM FEBRUARY 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner HARBOR MD N/A HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ■ M 2 M F Days Hours 215-14-9710 MARYLAND 29 09 1919 Director SEPTEMBER Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No **Funeral Director** N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 1118 S. EAST AVENUE 21224 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Ye ar or Dates: 1 ☐Yes 冷风No Specify: Specify: WHITE Completed by 3 Widowed 4 □ Divorced Pages 1 and 2 should be filed within 72 ho ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natur ury or other traumatic event, the Medical ury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE 11 DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FERDINAND HESSLER ည MYRTLE **EVANS** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOROTHY BRANDT/ DAUGHTER 1118 S. EAST AVENUE, BALTIMORE, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o 1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE NATIONAL 3/2/09 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility EILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PHEUMONIA /Medical Due to (or as a consequence of): Examiner HEART DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit VICER BLEEDING GASTRIC Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year signed by the aid 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe 2 PNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To in 24 hours after death.

he Funeral Director: After this pletely filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the P within 24 To the F and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 001 FEBRUALY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Sout 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Christopher Lee MAck 2009 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2139 Cockspur Road Middle River Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 **⊠** M 2 □ F Days 214-90-5766 34 Jan.10,1975 Director MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination and the notified at MD Director Baltimore Middle River 1 ☐Yes 2 No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2139 Cockspur Road 21220 USA Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. sont: If item 27 is marked other than "natural", or items 23 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Carpenter 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Mack Sharon Goslin ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau once. Sharon Goslin /mother 2139 Cockspur Road Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 3-3-09 Baltimore MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 300 Mace Ave.Balto. MD Connelly Funeral HOme of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Asphyxia **Physician** disease or condition resulting in death) D /Medical Due to (as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed Exami and burial-trai Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical ending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy fo Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a Ö 9 Unknown 9 Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 2 X No 2 No 1 Yes 1 Tyes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1**Y**Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred the Hospital or Attending 1 Natural suicide by Hanging 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur 1752P 1 ☐ Yes investigation 2 Accident March 1, 2009 6 Could not be determined 3 X Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City of Town, State) 2139 (OCKS pub Rd. M. Ldle River, Md. 21220 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical one) and manner stated.

State Registrar

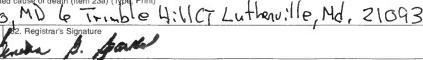
MAR 0 3 2009

M:1:

29b. Signature and title of certifier

h:1:0

31. Date filed (Month, Day,



who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

				epartment of Health and Certificate of Death	d Mental Hygie	2007 00001
	Physicia	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
-	/Medic	al	Darlene 4a. Facility Name (If not institution, give street and number)	Manns 4b. City, Town, or Location of De	02 2°	7 2009 1:45p. ^M
	Examin	er	Milford Manor Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Pikesvil	le	Baltimore
	Funeral Director		214-62-5315 1 M 2 MF 53		Min. (Month, Day, You 12 21	9. Birthplace (State or Foreign Country) MD
	ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	e Man	ctor	MD NA Ba	ltimore		X □Yes 2□No
	death with the Maryland rms 23a or 28e-f ehow rreat be notified at	I DIre	10e. Street and Number 3715 Bartwood Road	10f. Zip Code 21215	10g	Citizen of What Country? U • S • A •
0000	be filed within 72 hours after death with the Marylan stal Hyglene. or deme 23a or 28e-f ehow other then "naturel", or items 23a or 28e-f ehow event, the Modical Experiment reast be truitlised.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt 1 Yes Y No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
2	72 ho	ompleted	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working B	b. Kind of Business/Industry altimore City
7	e filed within al Hygiene. cther then "	dmo		Paraprofessiona		ublic Schools
and	ild be filed lental Hygi ked other ic event, II	BeC	17. Father's Name (First, Middle, Last)		Name (First, Middle, Ma	
<u> </u>	2 should be and Mental is marked o	၉	William T. Manns 19a. Informant's Name/Relationship (Type, Print) 19b.	Virgi Mailing Address (Street and Number of	nia Johns	
Z	9 5 5 5			15 Bartwood Roa		
more,	permit. Pages 1 en Depertment of Heal Important: if item 2 eny injury or other 2003.		M□Bunal 2 □Cremation 3 □Removal from State	Disposition (Name of processing of other place) odlawn 3/		altimore Co, Md
рашто	Depertm Depertm Importal eny inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility March F/H West		•
			23a. Par 1. Enter the the case, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	4300 wabash Avot enter the mode of dying, such as care		
	Physician		Immediate Cause (Final disease or condition resulting in death)	sir		Onset and Death
	/Medical Examiner		Due to (or as a consequence of	omyditis		11. home
	P11 / 诺	Iner	cause. Enter Underlying	f):	· · · · · · · · · · · · · · · · · · ·	
,	ficate be executed physicien end strength.	Examin	Cause (Disease or injury that initiated events resulting in death) Last C	f):		
09/80	ate be hysicie the bur	dlcal				
Ď X O	certific ading p		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
.c.	ures thet the death certifi signed by the attending d be detached for use as	Physician/M	in the past 12 mosms? 1 Yes 2 No 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
ras, r	requires thet the een signed by th hould be detache	þ	Part II. Other significant conditions contributing to death but not resulting in			2 PNo 3 Probably 4 Unknown
ecol		ompleted	Milet		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
I a	icien: The law certificate has b rector, page 2 s	e Cor	25. Was case referred tomodical	5		d2 death? No 1 Yes 2 No
>	S O D	To Be	examiner? 1 Yes 2 No	Other	Death (Check only one) ng Home 5 ☐ Residenc	e 6 □Other (Specify)
lou oi	ding After fune		27. Manney of Death 1. Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	ime of 28c. Injury at york? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred
DIVISION	el or Attending P s efter death. il Director: After i d in by the funera	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number. State)
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the basis of examination and and manner stated.	death occurred at the time, date and player investigation, in my opinion, death of	lace, and due to the caus occurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
		Me	29b. Signature and title of certifier	29c. License number	5	Date signed (Month, Dey, Year) 2 127 (0 9
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 G	Teeno Tr	ee Rd 7120f
-	Sta Registr		31 Date filed (Month, Day, Year) 2. Registrar's Sign ture	barlo		
DL	MH 17 Pay 1/2		MAR 0 3 2009 Rentur 7 17			

09-01599 Jibril Mustafa Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. For State Reg. No. Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day February 24, 2009 0722 hrs Medical Examiner Mustafa Jibril 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center **Baltimore** If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) g. Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director Country) 108-74-0618 Yrs 09 87 NV 1X M 2 F 21 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 X No Dundalk 23a or 28a-f show notified at ouce. Baltimore MD 10g. Citizen of What Country' 10f. Zip Code 10e. Street and Number 21222 1933 Guy Way U.S.A. ö Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. þe White, etc. Armed Forces? 1 X Never Married Marrier Yes 2X No Yes 2X No specify: Specify: Yes. Give Yea Bl<u>ack</u> Pages 1 and 2 should be filed within 72 hours after tent of Heat, h and Mental Hygiene. Widowed Δ Divorced Heat, hand Mental Hygiene. Fitens 27 is marked other than "natural", er tranmatic event, the Medical Examiner. þ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Middle River College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 Aircraft Systems Parts Technician 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Talibah Stevens Halim Mustafa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dundalk, Md 21222 1933 Guy Way, Dominic Taylor-Step-Father 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 2/28/09 lant: King Memorial Park Woodlawn, Md Other Specify: Donation 5 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, 21215 Part I. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line **∛**Medical Death a. Asphyxia Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of) b. Hanging Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical AMENDED UNPENDED attending physician or use as the burial requires that the death certificate be Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o þ Yes 2 ✓ No 3 Probably 4 Unknown Division of Vital Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? certificate has Yes 2 ✔ No Yes 2 26.Place of Death (Check only one Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifi 25. Was case referred to medical Be examiner? Hospital: Other₄ Residence 6 Other: ER/Outpatient 3 V DOA Nursing Home 5 Inpatient 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28b Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Subject hanged self FOUND: Natural Yes 2 ✔ No Pending Feb 24, 2009 0630 hrs 2 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 1933 Guy Way, Dundalk, MD determined (Specify) Rowhouse Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 25, 2009 O.C.M.E 1 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD 31. Date filed (Month-Day, Year) Registrar's Signa State Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician /Medica Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Environment be mailed at once. \mathcal{M} eore, $\mathcal{E}\mathcal{A}\omega\omega_{0}$ Baltimore, Maryland 21215-0036 Physician

/Medical

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

State

	1 - State Registrar	Certificate of Death	Reg. No. 2009 06353
20	1. Decedent's Name (First, Middle, Last)	2.	Date of Death Month Day Year 3. Time of Death
an :al	EDWARD MOORE		24 2009 3 4× AM
er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Franklin Square Hospital	enter Kosedale	Baltimore
	5. Social Security Number 5. Sex 7. Age (In yrs. las. 220 58 8690 1 1 1 2 1 5 3	birthday) If Under 1 Year If Under 24 Hrs. 8. Wonths Days Hours Min. T	Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) ULY 12,1955 MD
	Usual Residence of Decedent	113.	uly 12,1955 MD
		own or Location	10d. Inside City Limits
tor	MD n/a	Baltimore	1∏Yes 2∏No
irec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Completed by Funeral Director	5722 Arnhem Rd	21206	USA
ner	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specif	y Yes or No- 14. Race - American Indian,
Fu	Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 1 Never Married Never Married Never Ne	If Yes, specify Cuban, Mexican, Puerto Ric	
ð	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: NAVY	1 ☐ Yes 2 X No Specify:	Specify:BLACK
ete	15. Decedent's Education 1 (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business/Industry
ш	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	
ပိ	12th 17. Father's Name (First, Middle, Last)	Social Security Offic	
Be	Edward G. Moore, Sr.	· ·	irst, Middle, Maiden Surname)
ပု		Esther 1	
	Gregory Moore (brother)	19b. Mailing Address (Street and Number or Rural R	
			sterville, Ohio 43082 20c. Location - City or Town, State
	The purial 2 Decremation 3 the moval from State)	etery, crematory or other place) Feb. 28	,2009
	4 Donation 5 □ Other (Specify) Gree	n Mount Crematory	Baltimore Md
	Pos an Il Alice To As well	22. Name and Address of Facility Calvin B. Scrugo	gs Funeral Home
	23a. Part 1. Enter the disease, or complications that caused the death. I	1412 F Preston	St Ralto Md 21212
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	A ?	Interval Between Onset and Death
	disease or condition resulting in death)	GITHOSIS	
	Due to or as a consequen	ce on:	
ē	Sequentially list conditions, if any leading to himselfath cause. Enter Underlying	ris off:	
ä	cause. Enter Underlying Cause (Disease or injury that initiated events c.		
EX	resulting in death) Last Due to (or as a consequen	ce of):	
Medical Examiner	d		
Med	IF FEMALE:		
an/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
sici	1 Yes 2 No 4 Pregnant at time of deat		Month Day Year
Phy	9 LI Unknown		
Be Completed by Physician/	Part II. Other significant conditions contributing to death but not resultin	g in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ted			1 Yes 2 No 3 Probably 4 Unknown
nple			24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
ပ္ပ			performed death? 1 Yes 2 No 1 Yes 2 No
Be (25. Was case referred to medical examiner?	26. Place of Death (C	
	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER	Outpatient 3 DOA Other: 4 Nursing Home	5 Residence 6 Other (Specify)
on:	27. Manner of Death 28a. Date of Injury 28 1 ☑ Natural 5 ☐ Pending (Month, Day, Year)	D. Time of 28c. Injury at 28d Work?	Describe how injury occurred
cati	2 Accident investigation	M 1 □Yes 2 □No	
rti	4 ☐ Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	farm, street, factory, office 28f.	Location (Street and Number or Rural Route Number, City or Town, State)
Medical Certification: To	29a. Certifier 1 Certifying Physician: To the best of my knowle	dra death googyred at the time	due to the second (s)
dica	29a. Certifier (Check only one) 2	aye, death occurred at the time, date and place, and and/or investigation, in my opinion, death occurred a	que to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	+4() 11 m.	ν	
	30. Name and address of person who completed cause of death (Item 23	Kes 0000	restrucy, 27, 2007
	1/	000 FRANKLIN SOUARE DE	rebruary, 24, 2009 VE, BALTIMORE, MD 21237
e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	L. M.	VE DALTIMORE, MY XIX 27
ır	31. Date filed (Month, Day, Year) 32. Registrar's Signature NAR 0 3 2009	Tar.	
_			

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06354 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Year New pan 9:55 PM odda 2000 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 4831 Truesdale Avenue Raltimore Bastimore 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 215-83-4999 1 □ M 2 X F Months Days Hours Min Director 01/01/1933 Bhutan Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location items 23a or 28a-f show 10d. Inside City Limits event, the Medical Exeminer must be notified at Director MD Baltimore 1 XYes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4831 Truesdale Avenue 21206 Bhutan Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iter any Injury or other traumatic event, the Modical Exeminat once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2K No þ Specify: Specify: Asian 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Barma Lal Khatiwada Pabitra Ghimire ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bhagi Rath Neupane/Son 4831 Truesdale Ave., Baltimore, MD 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Cremation Services | 03/02/2009 | Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Gensee 22. Name and Address of Facility Ardent Cremation Services 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician STROKE disease or condition resulting in death) MONTHS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dissase or injury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans resulting in death) Last Box 68760, Due to (or as a consequence of) Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year P.O. 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s certificate 2 🗆 No 1 ☐ Yes 2 No 1 Tyes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After s after dec. rai Director: Aftr 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D Less certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

State

Registrar

ed (Month, Day, Year) **NAR 0 3 2009**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6505 N CHARLES ST, SUITE 209 DANIEUE DOBERMAN, MO 32. Registrar's Signature

D64395

FEBRUARN 23, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First_Middle, Last) 2. Date of Death Day **Physician** Month 2009 FEBRUALY 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSDIAM 20 BALTIMORE Himore (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** Year) Months Days 1 M 2□ F Hours Min. Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner nust be notified at 1 Kes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21 2 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 22 No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No <u>ک</u> Specify. 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 0 U) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ne ဥ 19a. Informant's Name/Relationship (Type. Print) _ daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra #103 taska Baltimore, 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date DaBurial 2 ☐ Cremation 3 ☐ Removal from State Jodlaws Cem 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 3405 Nancy Nallace 2,1229 xuto, md. Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s autopsy certificate performe 2 No Division of Vital 1 □Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending thours after death.
uneral Director: A
ely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Vithin 24 hours are
To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day,

LAOUSA

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06356 Reg. No. 2 1 1 9 Certificate of Death

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, In. "It dical Eventines must be notified at once. Baltimore, Maryland 21215-0036

Physici /Media Examir

Funeral Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death, To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

end	-trar	
he Funeral Director: After this certificate has been signed by the attending physician end	pletely filled in by the funeral director, page 2 should be detached for use as the burial-frar	
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-	1 - For State Registrar	Certificate of Death	Reg. No. 2 ()	06356
an	1. Decedent's Name (First, Middle, Last)	C	2. Date of Death Month Day Year	3. Time of Death
al	JAMES OWEW. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Ac. County of Dea	ath
er	Seasons Hospice	Kandall	stown Bo	retimare
	5. Social Security Number 341-24-4393 Usual Residence of Decedent 5. Sex. 12M 2 F 7. Age (In yrs. last b.	yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Bi	rthplace (State or Foreign ountry) Ath Cardina
		wn or Location		10d. Inside City Limits
ctor	md. Backmore F	ikesville		1 □Yes 2010
Funeral Director	7 Sudbrook Lane	10f. Zip Code 21208	10g. Citizen of What C	A
nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\subseteq \text{Never Married} \) 2 \(\subseteq \text{Married} \) 1 \(\subseteq \text{Ver} \) 2 \(\subseteq \text{No} \)	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - Am Black, Whi	
by F	1 ☐ Vever Married 2 ☐ Married In Yes, Give Year or Dates:	1 □Yes 2 ☑No Specify:	Specify:	SIACK
Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ia. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b. Kind of Business	s/Industry Telephone
Com	8th NIA	Driver		
Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maiden Surname)	
2	19a. Informant's Name/Relationship (Type. Print)	9b. Mailing Address (Street and Number or Rui	er or Rural Route Number, City or Town, State, Zip Code)	
	Bridget Fenner-daughter	10 613 6 11- 1	The Bowie N	nd:
	20a. Method of Disposition 20b. Place 20b. Place 20cemet 4 Donation 75 Other (Specify)	of Disposition (Name of tery, crematory or other place)	Date 20c. Location - City of Tyreil (Town, State
	21. Signature of uneral Service Licenses	22. Name and Address of Facility 27	Fith. Bactoin	Pass nd. 21229
	23a. Part Frie he lisease, or complications that caused the death. Do shock, or leart failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Immediate vuse (Final disease or condition Phe curs on L4			
er	resulting in death) Due to (or as a consequence of):			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e of):		
amir	that initiated events c.			
Medical Examiner	resulting in death) Last Due to (or as a consequence of):			
dica	d			
sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death		23d. Date of o	lelivery Day Year
by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown			
24a. Was an autopsy performed?				autopsy findings available
				o completion of cause of es 2 No
25. Was case referred to medical examiner?			ath (Check only one)	
		ome 5 ☐ Residence ☐ Other (S)		
tion	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28a. Date of Injury 28b. Time of Injury Work? 1 Natural 5 Pending (Month, Day, Year) 28b. Time of Injury Work? 1 Pyes 2 No			
ertifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
Medical Certification: To	29a. Certifier (Check only one) Check only one)			
Me	29b. Signature and title of sertifier	29c. License number	29d. Date signed (Mo	nth, Day, Year)
	1 (88 /81)M	DX870	1 MACh	1 2009
	30. Name and address of person who completed cause of death (Item 23:	1 mande Ch	PPR 251	136
ate	31. Date filed (Month, Day, Year) - 32. Registrar's Signature	B. fall		
rar	MAD 0 2 2000	- 17		

Regis

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MARY THERESA PRICE /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A . Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2□(F Days Hours 84 Director 218-36-1215 MAY 26,1924 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ns 23a or 28a-f show must be notified at 1 Yes 2 □ No Director MD N/A BALTIMORE the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 4304 PARKMONT AVE 21206 USA death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? i "natural", or item: ledical Examiner n Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: and 2 should be filed within 72 hours after lealth and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ Specify: WHITE 3 Widowed 4 □ Divorced Completed other than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES H. GORDON THERESA O'CONNOR is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4337 WINNER CIRCLE BEL CAMP, MD 21017 19a. Informant's Name/Relationship (Type. Print) NANCY MAYS-DAUGHTER permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition
1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State ATLANTIC CREMATORY 3/2/09 GLEN BURNIE, MD 4 ☐ Donation 5 ☐ Other (Specify) of Puneral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR RD BALTIMORE, MD 21206 . Enter the diseas , or heart failure complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical DIVERTICULITIS WITH PHLEYMON Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical as attending 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ OBSTRUCTIVE PULMONARY DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed OSTEOPOROSIS INFECTION TRACT 24a. Was an autopsy DECUBITI MULTIPL 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 ER/Outpatient 3 COA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: or Attending Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

5-0036

2121

Baltimore, Maryland

Box 68760,

P.0.

Records,

Division or Vital

MARK

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

RESODO

29d. Date signed (Month, Day, Year)

02

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAROLINE BAZTIMOR

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D2009 Evelyn Marie Peters March 1, **Physician** 4:45 P /Medical 4a. Facility Name (If not institution, give street and number) and Nursing 4b. City, Town, or Location of Death Shangra La Assisted Living Filicott City 4c. County of Death Examiner Ellicott City Howard Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 1 F Director July 6, 1939 Maryland 218-36-0931 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner and the political 1 □Yes 2√2 No Director Maryland Howard Ellicott City the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4475 Montgomery Road 21043 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XXNo Specify: ģ Specify: White 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Accounting 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Edgar Haynes Evelyn Marie King 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Pages 1 and 2 s tment of Health ar tant: If item 27 is jury or other trau Tirza Bensel Daughter 1513 Highvue Court, Forest Hill, MD 21050 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit, Pages Department of Important: If it any injury or o 1 → Burial 2 □ Cremation 3 □ Removal from State Meadowridge Memorial: 3/5/2009 Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CANCER disease or condition resulting in death) / /Medical Due to (or as a consequence of): Examiner (OPD Sequentially list conditions, if any, leading to immediate cause. Enter Uncerpage Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 autopsy death? 1 ☐ Yes performed' 1 □Yes 2 No 2 🗆 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of eath 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1 ■ Natural 2 ■ Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar

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Gulati, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3730 Falls Road

32. F

MA

Fegistrar's Signature

Baltimore, MD 21211

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		,	For 1_ State	State of I	Marylan	-	artment of		and M	ental Hy	giene	0.00	0.0001
			Registrar 1. Decedent's Name (First, Midd.	le, Last)		Ce	rtificate of	Death		2. Date of Dea	Reg. No	UU9	3. Time of Death
	Physicia /Medic			Virginia	Lee	Po	∞1e			Month Tebruar	Day	2009	12:15 A M
	Examin		4a. Facility Name (If not institutio				4b. City, Town,	or Location o				ounty of Dea	
			Gilchris 5. Social Security Number		Age (In yrs.	la a thiu tha da	If Under 1 Year	OWSON	04 Hrs	8. Date of Birl	· ·	Balti	
	Funeral Director		216–12–8045	1 M 2 1 F	88	Yrs.	Months Days		Min.	(Month, Da	y, Year)	1 9. B	rthplace (State or Foreign ountry)
	pu:		Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo	notion			100.	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 1 1	10d. Inside City Limits
	Maryla -f sho	to			Too. Oil								1 ☐ Yes 2 🔯 No
	or 28a	irec	Maryland Balt 10e. Street and Number	imore		Tows	10f. Zip Code				10g. Citize	en of What C	
	ath wil	Funeral Director	1055 W. Joppa	Road, Unit	532			204				U.S.A	
	items items	-une	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	12. Was Decede Armed Force	s?	S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origo an, Mexican,	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	- 14	 Race - Am Black, Whi 	erican Indian, te, etc.
036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show the Macical Evenine must be netfiled at	by	3 Widowed 4 □ Divorced	If Yes, Give	s:		1 □Yes 2 No	Specify:			8	Specify:	White
5-0	72 hc "natui	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during most	of workin	g	16b. Kind	d of Business	
72	within iene. than	omo	Elementary/Secondary (0-12)	College (1-40	or 5+)		do not use retire Homemake:				Or.	n Home	5
nd	be filed ntal Hyg ed other event,	Be C	17. Father's Name (First, Middle,	Last)			Michael		r's Name	(First, Middle,			
ylaı	should b and Ment s marked umatic e	2	Walte		Brov					Julia		ston	
Maryland 21215-0036	d 2 sh ith and ith it ith ith ith ith		19a. Informant's Name/Relations		1.								Zip Code) 28469
ē,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Healih and Mental Hyglene. If Item 27 is marked to the than "natural", or items 23a or 28a-f show or other traumatic event, the "notel Examine mast be notified at		Patricia P. Ke	, .	hter	lace of Dispo	Vindsor (sition (Name of natory or other pla	rcle		ean Isl			orth Carolina Town, State
Ē	Page ment c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from Sta Specify)	ile	ltop Se	ervice Co	orp. 3	3-3-2	2009	Tows	son	Maryl <i>a</i> nd
Baltimore,	permit. Pages 1 and 2.9 Department of Health a Important: If Item 27 Is any injury or other trac	į	21. Signature of Cuneral Service	7		22	. Name and Addr	ess of Facility	Ruc	k Tows	on Fu	neral	Home, Inc.
	407.00	_	23a. Part 1. Enter the disease, or	r complications that caus	sed the death		050 York			wson,		and 2	21204 Approximate
	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each	n line.	min	•	g,		,			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):							veres
	Lxaiiiiiei	er	Sequentially list conditions,	b	as a consequ	uence of):							
	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S c.									
8760,	be exe cian al ourial-t	EX	resulting in death) Last	Due to (or	as a consequ	uence of):			-				
687	death certificate be executed e attending physician and id for use as the burial-transit	edical		d									
Box	eath certific attending p for use as	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			7 Catania arangan				23	d. Date of de	elivery
о О	ne deat the att hed for	Physician/Med	in the past 12 months? 1 □ Yes 2 ဩ loo 9 □ Unknown	4 ☐ Pregnan	nt at time of d		J Ectopic pregnan ☐ Other (specify) _	су				Month	Day Year
<u>.</u>	w requires that the dispersion signed by the should be detached		Part II. Other significant conditi	ons contributing to death	n but not resu	ulting in the u	nderlying cause gi	ven in Part I.		23e. Did to	bacco use	e contribute t	o the cause of death?
Division of Vital Records,	en sign	Completed by	Vascular d	verne pul	moran	19 d	tense			1 □ Y	'es 2 □	No 3	robably 4 🗌 Unknown
ecc	e ław re has be je 2 sho	plet	Vascular d	itease						24a. Was a		24b. Were a	utopsy findings available completion of cause of
a E	n: The ficate !									perfor	med? 2 No	death? 1 ☐ Yes	
=	/sicial s certi directo	o Be	25. Was case referred to medica examiner? 1 ☐ Yes ♣ No	Hoenital:	atient 2 🗆	ER/Outpatier	t 3 DOA Ot			(Check only on ne 5 ☐ Resid		Othor (O-	MAROLL
n of	ding Physician: The h. h. After this certificate h. funeral director, page	n: T	27. Manner of Death 1 Natural 5 □ Pendir	28a. Date of I		28b. Time of Injury				Bd. Describe h	-		ecity) VUSICA
Sio	ttendii leath. tor: A the fu	catic	2 Accident investi	gation			M 1	Yes 2□N					
<u>></u>	after of Direct of in by	Certification: To	4 ☐ Homicide determ	nined 28e. Place of	etc. (Specif)		eet, factory, office		28	Bf. Location (S City or Tow	Street and in, State)	Number or R	ural Route Number,
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. Within E4 hours after death. Completely filled in by the funeral director, page 2 should be detached.	Medical C	29a. Certifier (Check only one) Certifyii 2 Medical	ng Physician: To the be Examiner: On the basis and manner	s of examinal	wledge, deatl tion and/or in	n occurred at the t vestigation, in my	ime, date and opinion, deat	d place, a h occurre	nd due to the d at the time,	cause(s) a date and p	ind manner a lace, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie				29c. Licen	se number	2		29d. Date	signed (Mon	th, Day, Year)
) Ylla				D	850	ンク	1	resu	LAM	26 2009
	10		30. Name and address of person	who completed cause o	f death (Item	23a) (Type,	Print) CUALLO	85 7	7.0	12.60	1 7	1700	
	Sta	e	31. Date filed (Month, Day, Year)	Z. Regi	strar's Signa		41	(020	NOW 10	W C	7 24	
	Registra	ar	MAR 03	2009 Kenyu	a p	. 40	100						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{,Day} 25 2009 **Physician** FEBRUARY LEONARD PAUL 10:51 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SINAI HOSPITAL BALTIMORE 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** Months Min. 1 X M 2 □ F Days Hours 09/01/1925 219-22-6734 83 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24 FENCEPOST COURT 21208 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 📜 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No WHITE Specify Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES LIQUOR DISTRIBUTING 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) MORRIS PAUL ပ LILLIAN GARBUS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FLORENCE PAUL / WIFE 24 FENCEPOST COURT, BALTIMORE, MD 20b. Place of Disposition (Name of ANSHE EMUNAH AITZ CHAIM 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Nation 2 □ Cremation 3 □ Removal from State 02/27/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death on gent disease or condition resulting in death) Hours Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of: Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 C Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 **□**-No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural

sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. attending physician for use as the buria P.O. ed by the Records, page 2 should has certificate Division of Vital this certific af director, funeral After death.

ithin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu Medical

Director

show

r than "natural", or items 23a or 28a-f st the Medical Examinar must be notified

permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, It we Medical Examinationate once.

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

5 Pending investigation 2 Accident 3 Suicide 6 ☐ Could not be determined 4 Homicide

29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

751896

29d. Date signed (Month, Dav. Year)

30. N me and address of person who completed cause of death (Item 23a) (Type, Print) ours MALIK

21249.

State Registrar

To the within 2

31. Date filed (Month, Day, Year)

			For State Registrar 1. Decedent's Name (First, Middle, 1		Ce	rtificate of			g. No2 0 0 9	0 5 3 6 3 3. Time of Death
	Physici	_	LOUIS EDGAR QUAN					Month FEBRUARY	Day Yea	
	/Medic Examin		4a. Facility Name (If not institution, g			4b. City, Town, o	or Location of Death		4c. County of De	eath
		φ.	5335 KENWOOD AVE			BALTIM	ORE		OVERLE	CA
	Funeral		5. Social Security Number 6 218-03-4508	1MOM OFF	(In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JUNE 22	Year) 9. E	irthplace (State or Foreign Country) MD
et.	Director		Usual Residence of Decedent	0				JUNE 22	,1920	ТШ
	how at		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Ba-f s	cto	MDOVERI	EA	BALTIM					1 □Yes 2 No
	with the	Dire	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What USA	Country?
	eath v	eral	5335 KENWOOD AV	12. Was Decedent B	ver in U.S. 13	21206		ecify Yes or No-		nerican Indian,
220	be filed within 72 hours after death with the Maryland ttal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces?	lo lo	If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, W	
5	72 hou natura Ilcal E	ted	15. Decedent's (Specify only highest	Education	16a. Dec	edent's Usual Occup	pation during most of work	ring	16b. Kind of Busine	ss/Industry
7	within 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retire PECTOR	d)	g	U.S. GOV	'ERNMENT
מוומ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Once.	To Be Co	17. Father's Name (First, Middle, La LOUIS CHARLES QU	•			18. Mother's Nam LENA S	e (First, Middle, M EEGER	flaiden Surname)	
<u>a</u>	2 should and Mer Is marke aumatic	-	19a. Informant's Name/Relationship	(Type. Print)	19b. Mai	ling Address (Street	and Number or Rui	ral Route Number,	City or Town, State	e, Zip Code)
2	1 and 2 Health em 27 l		CLAIR QUANTMEYER	R-WIFE		5 KENWOOD			E, MD 212	
2	Pages 1		20a. Method of Disposition Burial 2 □ Cremation 3	B □Removal from State	20b. Place of Disp cemetery, cr	osition (Name of ematory or other pla	ice)		20c. Location - City	
5	it. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Special Signature of Funeral Service Li			OF FAITH	Sess of Facility MI		BALTIMORE	
0	permit. Page Department of Important: If any Injury or once,		A Service City Carrel at Service City	Cerisee	1	6415 BELA			RE, MD 212	-
r			23a. Part1. Enter the disease, of co	omplications that caused nly one cause on each lin						Approximate Interval Between
ě,	Physician		Immediate Cause (Final disease or condition	_a. /	Prostate	Conce				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
b	æ	Jer	Sequentially list conditions, if any, leading to immediate	b	a consequence of):					
	rificate be executed ig physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
Š.	oe exe	EX	resulting in death) Last	Due to (or as	a consequence of):					
00/00	physicate to physical the b	edical		d						
O. BOX O	w requires that the death certif been signed by the attending should be detached for use as	sician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	су		23d. Date of Month	delivery Day Year
ŗ.	that the by detail	y Phys	Part II. Other significant condition	s contributing to death b	ut not resulting in the	underlying cause gi	ven in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
cords	quires in sign	ed by						1 □ Y€	es 200 3 🗆	Probably 4 ☐Unknown
20	law re as bee 2 sho	Completed						24a. Was a		autopsy findings available to completion of cause of
	sician: The law certificate has b irector, page 2 s	mo.						perform	ned? death	io completion of cause of ion 'es 2 No
	ysician: is certific director,	Be (25. Was case referred to medical examiner?	11		To		th (Check only on		
5		2	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie		SIII SE DON	her: 4 Nursing H		ence 6 Other (S	pecify)
NISION	ne Itel	Certification:	1 Natural 5 ☐ Pending investiga	(Month, Da	y Yea <i>r)</i> Injury	M 1]Yes 2□No			
	after de after de I Direct d in by t	ertifi	3 Suicide 6 Could no 4 Homicide determin	ed 28e. Place of Inju	ury - At home, farm, s c. (Specify)	street, factory, office		28f. Location (St City or Town	reet and Number or n, State)	Rural Route Number,
	To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best xaminer: On the basis o and manner sta	f examination and/or	ath occurred at the t investigation, in my	time, date and place opinion, death occu	, and due to the carred at the time, d	ause(s) and manne ate and place, and	as stated. due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	1.1	2,		se number		9d. Date signed (M	
+			> Who ch	laterful !	m	02	4356		March.	2, 2005
1			30. Name and address of person w	no completed cause of d	eath (Item 23a) (Type	e, Print)	4356	, 1	R.S.t.) /1 200

Registrar
DHMH 17 Rev 1/2001

State

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 28.2009 James B. Robertson, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. Months 1.X M 2 □ F **Director** 213-66-6831 February 22,1953 56 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Nedical Examinant must be notified at 10a. State 10b. County 10c. City, Town or Location Director MD. Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 USA 4000 E. Northern Pkwy. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Barnes & Noble Book Seller 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shirley Tennyson James B. Robertson, Sr. ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4000 E. Northern Pkwy. Balto.M d. 21206 Shirley Robertson Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-9-2009 Balto. City, Md. Bayview 21. Signature of Funeral Service Censee 22. Name and Address of Facility Schimunek Funeral Home Driem 1) Jeurs 9705 Belair Rd. Nottingham, Mdd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) SQUAMOUS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ Completed filled in by the funeral director, page 2 should 24a. Was an autopsy performed? Yes 2 DINo 1 ☐ Yes Be 25. Was case referred to medical examiner?

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28a. Date of Injury (Month, Day, Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Day

Year

3. Time of Death

1305

Birthplace (State or Foreign Country)

Maryland

White

10d. Inside City Limits 1 ☐ Yes 2 No

Approximate Interval Between Onset and Death

cuaroth

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Dether (Specify) NUSPILE

28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

5

completely

Certification: To

Medical

1 Yes 2 No

5 Pending

investigation 6 Could not be determined

27. Manner of Death

1 Natural

2 ☐ Accident

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

To the Hospital within 24 hours a To the Funeral C

29c. License number

		artment of Health and Menta rtificate of Death	al Hygiene Reg. N2 009 06365
Physician /Medical	1. Decedent's Name (First, Middle, Last) James F. Reilly	Mo 2	
Examiner Funeral Director	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER 5. Social Security Number 6. Sex 1 M 2 F 67 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Da Months Days Hours Min. (Min.	te of Birth onth, Day, Year) 9. Birthplace (State or Foreign Country) rch 4,1941 Maryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. To Be Compieted by Funeral Director	10e. Street and Number 1212 Washington Irving Lane 11. Marital Status 1	Was Decedent of Hispanic Origin? (Specify Yelf Yes, specify Cuban, Mexican, Puerto Rican, Specify Cuban, Mexican, Puerto Rican, Specify: Specify: Spe	Specify: White 16b. Kind of Business/Industry Manufacturing Middle, Maiden Surname) Y e Number, City or Town, State, Zip Code) ane Middle River, Md. 2122 20c. Location - City or Town, State 09 Balto. City, Md.
ate be executed cate be executed by sician and cate be unial-transit the burial-transit dical Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dreaded or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	ter the mode of dying, such as cardiac or respi	ratory arrest, Approximate Interval Between Onset and Death
ecords, P.O. Box 6 aw requires that the death certifi as been signed by the attending t 2 should be detached for use as pleted by Physician/Mee		DIABETES	23d. Date of delivery Month Day Year 3e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 1a. Was an autopsy findings available prior to completion of cause of
n of ng Phy offer this ineral di	25. Was case referred to medical examiner? Yes 2 No	26. Place of Death (Check of Death) 1	performed? death? Yes 2 No 1 Yes 2 No ck only one) Residence 6 Other (Specify) escribe how injury occurred cation (Street and Number or Rural Route Number, by or Town, State)
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ti	29a. Certifier (Check only one) 1	th occurred at the time, date and place, and dunvestigation, in my opinion, death occurred at the 29c. License number	te to the cause(s) and manner as stated. he time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 2 - 2 4 - 2 00 9
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, DR Robert Green wold Good F 31. Date filed (Month, Day, Year) NAR 0 3 2009 Registrar's Signature		2 Balto md 21237

1

James

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 27, 2009 2:54 A M February Georgia Hash Reeves 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Harford Memorial Hospital Havre de Grace If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, June 27 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Days Hours Year 1 M 2 X Maryland 1919 89 214-30-3142 Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Havre de Grace Maryland Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1 Hopewell Road 21078 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. Specify. 3 XWidowed 4 ☐ Divorced White 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 11 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Spencer (nmn) Thomas H. Hash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stephen J. Reeves / Son 1 Hopewell Rd., Havre de Grace, MD 21078 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Deer Creek Harmony 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Presbyterian Chr. Cem. 3-2-09 4 □ Donation 5 □ Other (Specify) Darlington, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 this that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. COLLINGSTIVE HEART FAILURE ant1. Enter the disease, or coms shock, or heart failure. List only on a Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ONGESTIVE Due to (a a consequence of): Ascites Sequentially list conditions 3d. Date of delivery Month Dav Year se contribute to the cause of death? 3 ☐ Probably 4 ☑ Onknown No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ► No

Physician /Medical Examiner

Physician

/Medical

Director

Funeral

2

Completed

Be

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Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifiled at

permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any Injury or other traumatic event".

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner burial-transi sate has been signed by the a page 2 should be detached within 24 hours a er death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	2
	Part II. Other significant conditions o	ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did toba 1 □ Yes 24a. Was an autopsy	s 2[
		perform 1 □ Yes 2	ned? ☑ No
i	25. Was case referred to medical	26. Place of Death (Check only one	<u>)</u>
I	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Resider	nce 6
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No	w injury
l	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street, building, etc. (Specify) 28f. Location (Street, factory, office 28f. Location (Street, fa	eet an

☐Other (Specify) d Number or Rural Route Number, 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only

one) 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D42800

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

501 S'. UNION AVE HAVRE de GRACE, MD 21078 MOMAS 32 Registrar's Signature 31. Date filed (Month, Day,

State Registrar

10

			1 - State of Ma	ryland /	Department Certificate		and Mental Hy	ygiene Reg. No. 20 (9 06367
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Bonnie Carol	Raile	у		2. Date of D Month	eath	3. Time of Death
	Exami		4a. Facility Name (If not institution, give street and number) Franklin Square Ho	ospita	4b. City, To	own, or Location		4c. County of	Death Tono
	Funeral Director			(In y s. last t	Yrs. If Under 1 Months	Year If Under Days Hours	r 24 Hrs. 8. Date of B Min. (Month, E Dec. 1	irth Day, Year) 15, 1962	Birthplace (State or Foreign Country) Maryland
	sryland show	_		•	wn or Location				10d. Inside City Limits
	death with the Maryland ims 23a or 28a-f show	Director	Md . N/A 10e. Street and Number	Bait	imore 10f. Zip C			10g. Citizen of Wh	
	r death w tems 23a	Funeral	625 S. Potomac St. 11. Marital Status 12. Was Decedent Every Armed Forces?	ver in U.S.	13. Was Decede	21224	rigin? (Specify Yes or N n, Puerto Rican, etc.)	0- 14. Race	American Indian, White, etc.
0036	hours after tural", or ite	ρ	↑ Never Married 2 Married 1 Yes 2 No No If Yes, Give Year or Dates:	5	1 □ Yes 2[Specify:	White
1215-	within 72 h ene. than "nat	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+ 5+		ia. Decedent's Usual (Give kind of work life. DO NOT use	done during mo	st of working	Account	,
and 2	be filed Ital Hygi d other event, I		17. Father's Name (First, Middle, Last) John P. Railey, Sr.				er's Name (First, Middle arolyn Zim	1	
Mary	d 2 should th and Mer 7 is marke traumatic	7	19a. Informant's Name/Relationship (Type. Print) Mrs. Christina Jenkins/ Sist			Street and Numb	per or Rural Route Numb	ber, City or Town, Si	
altimore,	Pages 1 an nent of Hea int: If item 2 iry or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place cemet	of Disposition (Name lery, crematory or other	of er place)	Date 3-2-09	20c. Location - Ci	ty or Town, State
Baltin	permit. P. Departme Importani any Injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Furieral Service Licensee	Parkwo	ood Cemete 22. Name and Ruck	Address of Facil	Funeral Ho	me. Inc.	re, na.
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	he death. Do	1050	York R	<u>1. lowson, </u>	<u>Ma. 21</u> 204	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a	consequence	MOCK e of):	D			
\ V		niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events . c.	consequence	apy fo	r brec	rst Can	Cinomic	
8760, 4	cate be executed physician and the burial-transit	al Examine	that initiated events resulting in death) Last C Due to (or as a	consequence	e of):				
9		/Medical	IF FEMALE: 23c. If yes, outcome of	f programm:					
P.O. Box	Hospital or Attending Physician: The law requires that the death certificate hours after death. A hours after death. Funeral Director: After this certificate has been signed by the attending I telled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	Fetal deat	th 3 Ectopic pres	gnancy hify)		23d. Date of Month	
	ires that t signed by I be detac	ρ	Part II. Other significant conditions contributing to death but	not resulting	in the underlying cau	se given in Part		_	ute to the cause of death?
Division of Vital Records,	e law requir has been s e 2 should	Completed					24a. Was	an 24b. We	Probably 4 Unknown re autopsy findings available of to completion of cause of
/ital F	yslcian: The la is certificate hadirector, page 3	Be Cor	25. Was case referred to medical examiner?			26. Place	perfo 11 Yes of Death (Check only of	ormed? des 2 □ No 1	uth? LYes 2 □ No
of	Phys or this oral dir	1: To			Outpatient 3 DOA Time of 28c		ursing Home 5 Resi	idence 6 Other	(Specify)
ision	ttending death. stor: Afte / the fune	Certification: To	1 Natural 5 □ Pending (Month, Day, 2 □ Accident investigation		Injury M	. Injury at Work? 1 □ Yes 2 □	No		
Div	To the Hospital or Attending Physical within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.		4 Homicide determined 256. Place of Injury building, etc.		arm, street, factory, o		City or To	wn, State)	or Rural Route Number,
	the Hos hin 24 h the Fun πpletely	Medical	one) Medical Examiner: On the basis of e	examination a ed.	and/or investigation, ir	n my opinion, dea	ath occurred at the time,	date and place, and	er as stated. I due to the cause(s)
	vith vith To tl	Σ	29b. Signature and title of certifier DR. 3 A Rus 30. Name and address of person who completed cause of dea 9 1 100 Purmum Squ 31. Date filed (Month, Day, Year) MAR 03 2009 Service State of the service of the s	ANE	29c. L	icense number	000	29d. Date signed (I	Month, Day, Year)
	10		30. Name and address of person who completed cause of dea	ith (Item 23a)	(Type, Print)	NP LI	217	1 0 -	-, - ,
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's	s Signature	base		- 381		
	Registr	ar	MAK U D ZINIS COMPA	M. 14			 -		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 009

		State Registrar Decedent's Nam-	e (First, Middle,	Last)		Ce	partment ertificate		th	2. Date of D	Reg. No.	009	3. Time of De
Physician /Medical Examiner	4a.	FUTUR	If not institution, CA	Die sireet and received	number)		BI		امدر	Month 3	95 Ac. C	County of Dea	A
Funeral Director	do	Social Security N 30-33- Ial Residence of	9915	6. Sex 1 □ M 2 F	7. Age (In	yrs. last birthda 79 Yrs.	y) If Under 1 Months [Year If Und Days Hour		8. Date of B (Month, D	irth lay, Year) B 195	9. Bir	thplace (State or Foountry) ARY ANG
or 28a-1 show or 28a-1 show or Director	10a	. State MD	10b. County	1/4	100	c. City, Town or BAL	Location	re					10d. Inside City L
th with the Mar 23a or 28a-f sl ust be nutified	10e	Street and Nui	Be v	ant i	Aver	nue	10f. Zip C	0de 212	17		10g. Citize	on of What Co	ountry?
urs after dea at', or ttems		Marital Status 1 ☐ Never Marr 3 X Widowed	ried 2 Marrie	12. Was De Armed 1 Yes if Yes, 0	ecedent Ever Forces? s 2 X No Give r Dates:	in U.S. 13	3. Was Deceder If Yes, specify	Cuban, Mexi	can, Puerto I	cify Yes or N Rican, etc.)		Black, Whi	erican Indian, te, etc.
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Mental H Mental H arked oth attc even	17.	Willi		Curti	S			G	ertro	(First, Middle	HOP	okin.	5
os 1 and 2 sho of Health and I item 27 Is mu r other trauma	6	a. Informant's Na	Relationsh	ip (Type, Print) AJ/	500	19b. Ma 73 Ob. Place of Dis	iling Address (S $34B$	ryas.	Ther or Rura				Zip Code) LID - R
permit. Pages Department of Important: If it eny injury or o	21.	4 Donation			m State	1 1 1	iematory or other 5 Hemo 22. Name and 5340 K		Ark cility Cha crestor	4109 2100 100 K	Arb	tus, i	HARYLAI Inenal Hu ore HDá
Physician /Medical Examiner	Imi	a. Part1. Enter the shock, or hea mediate Cause ease or condition sulting in death)	(Final	complications that only one cause or a	it caused the	ful C	Olto (1	of dying, such	as cardiac o	r respiratory	arrest,		Approximate Interval Betwee Onset and Dea
LAdimilei					to (ór as a coi	nsequence of):	01,00						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician 9, 2009 6:56 PM M February Camile Spencer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital 9. Birthplace (State or Foreign Country)
North Carolina If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Oct 20, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Min. Days 1 □ M 2 🔯 F Hours 70 1938 Director 244**-**54-8808 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits or items 23a or 28a-f show 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene. em 27 Is marked other than "natural", or items 23a or 28a-f shov wher traumatic event, the Worldon Exerting in the confiler Director 1 ☐ Yes 2√ No District Heights Prince George's 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3307 Walters Lane #2 20747 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 ☐Yes 2 ☑ No Specify: 2 Specify: black 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 0 disabled none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Henderson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra Doris Spencer/daughter Walters Lane #2 District Heights, MD 2
on (Name of Date 20c. Location - City or Town, State 3307 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 HOther (Specify) in state 21. Signature of Funeral Service Licensee

Ronald S. Wade, Pricector 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. P. rt1. Enter the disea w, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Acute Artenoscieratic Corclinionasculor disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to for a consequence of: Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. if yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 1 □ Yes 2 3 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 111 D0062057 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 USRRATTS ROAD CLINTON, MARYLAND 20735 BANKS M.D. SANDRA 3 Registrar's Signat 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

09-01049 Theodore Scott Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 06370

		For State			Cer	tificate	of Death			Re	eg. No.	000	0031
Physicia Medical Examir		Decedent's Name Theodore							c ⁼	Date of Deat Month		-	me of Death 545 hrs
ieuicai Examir				n, give street and nun	mber)		4b. City, Tow	n, or Location	n of Death	Month February 4	4, 2009 4c. County of		045 Nrs
				e, Apartment 31	,		Baltimo						
Funeral Director	5.	Social Security Nu	mber unk	6. Sex	7. Age (In yrs. la	• ,		Year If Un Days Hou	der 24Hrs. Irs Min.		th(MM/DD/YYYY	9. Birthplace Foreign Country)	e (State or unk
any	_	sual Residence of Da. State	Decedent 0b. County		10c. City,	Town or Lo	cation					10d.	Inside City Limits
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ems 2.	Funeral	Marital Status Never Married	un 1 2 Ma	12. Was Dece	edent Ever in U.		Was Decedent of	of Hispanic O	rigin? (Spe	ecify Yes or No-	- 14. Race White	- American In	dian, Black,
s afte	<u>_</u> 6	3 Widowed	4 Div	1 Yes orced If Yes, Give Year	2 No	1	Yes 2X	No specif	fy:		Specify:	black	1
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5-0(led wi Hygier other		7. Father's Name (F	irst, Middle,	Last)			uı	1k 18.Moth	er's Name	(First, Middle, N	Maiden Surname))	unk
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, MD 21215-0036 and 2 should be filed within 72 lealth and Mental Hygiene, ten 27 is marked other than 'traumatic event, the Medical	요 1	Θ a. Informant's Nam $O \cdot C \cdot M \cdot E \cdot$	ne/Relations	hip (Type, Print)			Penn S				nber, City or Town		Code)
re, MD s I and 2 sho of Health and If item 27 is ner traumati	20	Da. Method of Dispo	sition			Place of Disp	osition (Name		T	Date	20c. Location -		State
more	1	Burial 2		3 Removal fro pecify: in s∤ta	III State	rematory or	other place)						
Baltimore, MD 21215-003 permit Pages I and 2 should be filed within Department of Health and Mental Hygiene, Important: If item 27 is marked other thinjury or other trammatic event, the Med	2	1. Signatur 1 Frine	oral Service	Licensee	. <u></u>	22	2. Name and Ad	dress of Facil	lity	(55.77	Baltim		
യ ഉള ⊡		20 11/1/1/1	1/1	complications that ca									reet
Physician / Medical	23	Ba. Part I. Enter the failure List only	disease, or, one cause	on each line.									proximate Interval tween Onset and
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8760, tificate be ng physici as the buri	Z 1F	FEMALE: b. Was decedent pr	egnant in th		utcome of pregr rth		Fetal death	3 Ector	oic pregnar	ıcy	23d. Date of Month	delivery Day	Year
Box 68 death certif	rsician	past 12 months? Yes 2 No	a IInk	DOWE	int at time of dea	ath	Other (Specify)					,	
D. Be t the de	€∟			ons contributing to		esulting in th	e underlying ca	use aiven in l	Part I	23e Did to	bacco use contri	hute to the ca	use of death?
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Vita hysicia this ce	O Be	examiner? 1 ✓ Yes 2	No	Hospital: 1 In	patient 2	ER/Outpatie	ent 3 DOA	Other	Nursing	Home 5	Residence 6	Other: Scen	e
ing Ph	1 4/	'. Manner of Death X Natural	_ [777]		of Injury Day,Year)	28b. Time o	11	. Injury at Wo	_	28d. Describe h	now injury occurre	ed	
Sior Attend death death sctor: by the			5 Pend Inves	tigation				Yes 2					
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed than 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and uppletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Certification 3 4 5 5	Homicide		d not be mined (Specify)	of Injury - At ho	me, farm, st	reet, factory, of	rice building,	etc.	28f. Location (S or Town, Si		er or Rural Ro	ute Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	edica	2 M	edical Exar	ysician: To the best niner:On the basis of and manner sta	examination ar		gation, in my op	inion, death o	occurred at				e(s)
0	≥ 29	b. Signature and tit	re of certifier	10				cense numbe	er		29d. Date signe		ay, Year)
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		Ling Li, MD Date filed (Month)	Assistar	who completed cause of Medical Exam	,	Penn Str	eet, Baltimo	re, MD 21	201				
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		For State Registrar		State c	it Maryla		artment of I <i>rtificate of</i>				giene Reg. No 2 (09	06371
Dh i ai		1. Decedent's Name (First	,	,						Date of Dea		Year	3. Time of Death
Physicia /Medic	al	VOLUR				HAF				ebru		2009	1250 A M
Examin	er	4a. Facility Name (If not in Seasons Ho		street and nu	mber)		4b. City, Town, o					nty of Death Baltimo	re
Funeral		5. Social Security Number	6. Se		7. Age (In y	rs. last birthday,				Date of Birt (Month, Da			lace (State or Foreign
Director		220-20-5737 Usual Residence of Dece		□M 2 ∑ F	81	Yrs.	World Days	Hours	6	/20/19	927		yland
yland now			County		10c.	City, Town or Lo	ocation					10	Od. Inside City Limits
with the Maryland a or 28a-f show	Director	MD	n/a		E	Baltimor	re .						1XYes 2□No
vith the	Dire	10e. Street and Number					10f. Zip Code					of What Count	try?
eath v	Funeral	1110 Pine He	eights	Avenue		U.S. 13.	Was Decedent of I		Origin? (Specify	Yes or No	USA 14. B	A Race - America	an Indian
72 hours after death with the Maryland natural", or items 23a or 28a-f show	ρ	1 □ Never Married 2) 3 □ Widowed 4 □ Di	-	Armed Fo 1 □Yes If Yes, Gi Year or D	rces? 2 😿 No		Was Decedent of I If Yes, specify Cub 1 □ Yes 2 X No			an, etc.)	Spec	lack, White, e	etc.
ithin 72 ho ne. han "natur	Completed	15. D (Specify only Elementary/Secondary (cation le completed) College (1-4or 5+)	(Give	edent's Usual Occu kind of work done DO NOT use retire	pation during mo d)	ost of working		16b. Kind of	Business/Ind	ustry
filed within Hygiene. other than '		12 17. Father's Name (First, I	Middle Last)	0		Home	emaker	18 Mot	ther's Name <i>(Fi</i>	irst Middle		Home	_
ld be f lental ked o ic eve	To Be	William G. C	·						nnie	rot, middio,	maracii caii	21110)	
shou and M s mar	-8	19a. Informant's Name/Re	elationship (T	vpe. Print)		19b. Maili	ng Address (Street	and Num	nber or Rural R	oute Numbe	er, City or Tow	vn, State, Zip	Code)
and 2 lealth m 27 i	9	John R. Scha		Husban									yland 2122
permit. Pages 1 and 2 should be filed within 2 Department of Health and Mental Hygiene Important: If item 27 is marked other than "rany injury or other traumatic event, If Item 2000.		20a. Method of Disposition 1 X Burial 2 ☐ Cren 4 ☐ Donation 5 ☐ O	nation 3 🗆 I		State I	_	osition (Name of matory or other pland Mem. Go		3/4/20			n - City or Tov ottsvi	un, State
permit. Depart Import any inj once.		21. Gignatury of Funeral S	Service Licens	Son!	l		2. Name and Addre						
		23a. Part 1. Enter the dise shock, or heart failur	ease, or comp re. List only o	lications that one cause one	aused the de								Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	_	a	neo	mo	riA						Onset and Death
/Medical Examiner		resenting in death,	•	Due to	(or as a cons	equence of):							
7 +	ner	Sequentially list conditions if any, leading to immediat Cause (Disease or injury	s, e	b. Due to	(or as a cons	equence of):						- 1	
ecuter and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	C	/								
ificate be executed g physician and as the burial-transit	edical E			d	(or as a cons	equence oi):							
		IF FEMALE:		23c. If yes, ou	come of pred	nancy							
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnin the past 12 months 1 ☐ Yes 2 No 9 ☐ Unknown	anı	1 Live	birth 2 ☐ Fe nant at time o	etal death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	су				Date of deliver Month [ry Day Year
e law requires that the d has been signed by the le 2 should be detached	þ	Part II. Other significant of	conditions co	ntributing to d	eath but not r	resulting in the u	nderlying cause giv	en in Part	Din		obacco use co ′es 2 ☐ No		e cause of death?
w requ	lete	Peral	FA	duse	7	/ 0270		<u></u>		24a. Was a	an 24t	o. Were autor	osy findings available
r: The la licate ha r, page 2	Completed	Ahra	4	Rih	r, U	sha	5				sy med? 2 No	prior to com death?	npletion of cause of 2 No
rsiciar s certii iirecto	o Be	25. Was case referred to r examiner? 1 ☐ Yes 2 ☑ No	⊢	Hospital:	Innationt 2	☐ ER/Outpatie	ot 3 🗆 DOA Oth		ce of Death <i>(C</i> Nursing Home			When (0 16	A TT 1
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	tion: To	27. Manner of Death	Pending investigation	28a. Date	`	28b. Time o	f 28c. Inju Wor	ry at	28d.		ow injury occi	Other (Specify, urred	/ Hospice
al or Atter after des I Director d in by th	ertification:	3 ☐ Suicide 6 ☐	Could not be determined	28e. Place buildi	of Injury - At ng, etc. (Spe	t home, farm, str ecify)	reet, factory, office		28f.	Location (S City or Tow		nber or Rural	Route Number,
e Hospita 1 24 hours e Funera letely fille	Medical C			iner: On the b			th occurred at the tinvestigation, in my						
To th within To th	M	29b. Signature and title of	certifier		52		29c. Licens	se number	r		29d. Date sigr	ned (Month, D	Jay, Year)
		low	98	200	102		D15	8	72	_ 7	chru	cy 25	2009
		30. Name and address of	person who c	empleted caus	se of death (If	tem 23a) (Type,		- 5	KERM	2	21/3	36	
Sta	te	31. Date filed (Month, Day,	Year)	32. F	egistrar's Sig								
Registra	ar	MAR	03 20	19 1		I A							

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State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	Certifi	icate of l	Death	Montai	Reg.	No.2009	06373
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date o	f Death	Day Year	3. Time of Death
	/Media		Lennart A. Sundquist				02-2	4-20		12:48 P ^M
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b.		Location of Dea	ath		4c. County of Dea	
and a		-	1983 Blair Ct 5. Social Security Number 6. Sex 7. Age (In yrs. last birt	thday) If I	Bel .	Air If Under 24 Hr	rs 9 Data a	f Dieth	Harfo	
	Funeral Director		1 W 10 0 5		onths Days	Hours Mil	n. (Month	f Birth , Day, Yes 3-19	36 9. Bi	rthplace (State or Foreign ountry) NY
	/land		10a. State 10b. County 10c. City, Town	or Location	n					10d. Inside City Limits
	Ba-f sh	Director		Air						1 □Yes 2 😿 No
	h with th		10e. Street and Number 1983 Blair Ct	10	0f. Zip Code 210	015		_	Citizen of What C SA	ountry?
	ems :	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was I		ispanic Origin? (In, Mexican, Pue	(Specify Yes o		14. Race - Am	
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. Fire is marked other than "natural", or items 23a or 28a-f show ther traumatic event, I're Medical Exemity mast be rutified at	þ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	l _	es 2MNo	Specify:	ito nicali, etc.	,	Black, Whit	White
15-(n 72 h	Completed	(Specify only highest grade completed)	(Give kind of	s Usual Occupa of work done of IOT use retired	turing most of w	orking	16b.	Kind of Business	/Industry
212	d withi	mo	Elementary/Secondary (0-12) Sollege (1-4or 5+) En	ginee		,		В	GE	
פ	al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)	-		18. Mother's Na	ame (First, Mic	idle, Maid	en Surname)	
<u>Ja</u>	uld by Menta arked	ToE	Gustar A. Sundquist			Astrid	Nelson			
lar)	2 sho and is me			Mailing Add	dress (Street a	and Number or I	Rural Route No	ımber, Cit	y or Town, State,	Zip Code)
<u>ک</u>	ges 1 and 2 should nt of Health and Mer if Item 27 is marke or other traumatic					t Bel Ai				
Baltimore,	permit. Pages 1 Department of I Important: If Ite any injury or ot		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of cemetry Bayvier	w Cre	matory	02-	Date -28-200	9 Ba	Location - City or	, MD
Balt	permit Depart Import any inj once.		21. Signature of Funeral Service Licensee Bucin C. Welle	22. Nan	me and Addres	ss of Facility Sc	himune	k Fur	neral Hor	me of BelAir
Е			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.						1119 1110 2	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Metartutic Louise Louise (Final disease or condition resulting in death)	n:	Can	cinem	a			S) x months
		e	Sequentially list conditions, if any, leading to humodiate	De .						
19.	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to thin codate cause. Enter Underlying Cause (Disease or injury that initiated events	.,.						
60,	certificate be executed rding physician and ise as the burial-transit		resulting in death) Last Due to (or as a consequence of	f):						
68760,	ificate g phys is the	Medical	d		-					
ñ	eath atter for u	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		opic pregnancy er (s <i>pe</i> c <i>ify)</i>			-	23d. Date of de Month	livery Day Year
Records, P	uires that n signed t Id be deta	þ	Part II. Other significant conditions contributing to death but not resulting in	the underly	ring cause give	n in Part I.		id tobacco		o the cause of death? robably 4 ☐ Unknown
ဂ ္ဂ	aw rec is bee 2 shou	olete					24a. W	as an	1	utopsy findings available
a Y	r: The la	Completed						utopsy erformed? s 2 🗚	prior to death?	completion of cause of
VITal	sicial certii irecto	Be	25. Was case referred to medical examiner? Hospital: Hospital:		044-	26. Place of De				
Ö i	r this aral di	٩	27. Manner of Death 28a. Date of Injury 28b. Ti		J DOA	4 LI Nursing		_	6 ☐ Other (Spe	cify)
<u>.</u>	nding th. :: Afte	랿	1 Natural 5 Pending (Month, Day, Year) Inj 2 Accident investigation	ury M	28c. Injury Work? 1 □ Y	? ′es 2 ∐ No	200. Descri	oe now mj	ary occurred	
DIVISION OF	al or Affe after des Director d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, fa	ctory, office		28f. Locatio City or	n (Street a Town, Sta	and Number or Ru te)	ural Route Number,
		g	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, and manner stated.							
	vithir To th comp	Me	29b. Signature and title of certifier		29c. License	number		29d. D	ate signed (Mont	h, Day, Year)
	0	-	29b. Signature and title of certifier Mandwelld Luin, M.D. 30. Name and address of person who completed cause of death (Item 23a) (T. Mandwell A. Levino 1569 North C. Mandwell A. Levino 1569 North		DA	573		Fe	bruary	27,2009
	8		Mansfull A. Levine 1569 North Cl	ype, Print	954 1	3a Him.	ine /	lany	land	21204
	Stat Registra	e ir	NAR 0 3 2009 32. Registrar's Inatural State filed (Month, Day, Year)	Acres				-		

DHMH 17 Rev 1/2001

09-01632 David Sanders

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

zana canacio		1-For State Registrar Certificate of Death		J. No. 0	000
Physici Medical Exami		1. Decedent's Name (First, Middle,Last) David Sanders	Date of Death Month February 2	Day Year 5, 2009	2 Time of Death 3
t-		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Severna Park Severna Park		4c. County of Anne Arur	
Funeral Director		186-58-7199 1X M 2 F 45 45 Yrs. Months Days Hours. Min.	8. Date of Birth 7/27/1		g. Birthplace (State or Foreign Country) PA
and show any	o	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Severna Park			10d. Inside City Limits 1 Xyes 2 No
h the Maryl 3a or 28a-	I Director		109	g. Citizen of What USA	Country?
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygene. ut: If item 27 is marked other thau "natural", or items 23a or 28a-f show r other traumatic event, the Medical Examiner must be notified at once.	eted by Funeral	11. Marital Status 1 XNever Married 2 Married 1 Yes 2 X No 3 Widowed 4 Divorced or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes 2 X No specify: 1 Yes 2 X No specify: 16a. Decedent's Usual Occupation (Give kind of word during most of working life. DO NOT use retired	can, etc.)	14. Race - / White, 6 Specify: 16b. Kind of Busin	White
0036 within 7 iene. ner thau	Completed	12 1 Labor Worker		Constr	uction
21215-0036 build be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Donald Joseph Sanders 18. Mother's Name (First, Middle, Last) Jane Aud 19b. Mailing Address (Street and Number or Rur	drey Bo	rthwick	
MD 2 und 2 shoul salth and N em 27 is n	ř	Donald P. Sanders / Brother 536 Knollwood Road, Se	everna l	Park, MD	21146
Baltimore, MD 2 permit Pages 1 and 2 shoul Department of Health and Important: If item 27 is m injury or other traumatic		1 Burial 2 Xcremation 3 Removal from State crematory or other place) Ardent Crematory 2/28	3/2009	20c. Location - Ci	
		21. Signature of Funeral Service Licentsee Cro rs Maryland Cremation Po Box 1413, Balti	more,Mu) 21203	
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or refailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Complications of chronic alcohol abus Due to (or as a consequence of):		t, shock, or heart	Approximate Interval Between Onset and Death
	ie l	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence or): Due to (or as a consequence or):			
uted da ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
e executed sian and rial - transit	Medical E	XUNPENDED 23a,PII,27,perME, g890 4/24/09	TT		
760, ficate be g physici		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of de	
Box 687 e death certific the attending p	Physician/	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) g Unknown	<i>'</i>	Month	Day Year
ires that the displayed by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Emphysema			e to the cause of death? Probably 4 Unknown
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed redeath. retor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial—transi	Completed by		24a. Was an autopsy perform	prior ed? deat	e autopsy findings available to completion of cause of th? Yes 2 No
Vital Recysician: The his certificate director, page	8	25. Was case referred to medical examiner? 1 Ves 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Nursing H			
ision of Vi Attending Physi er death. rector: After this	ation: To	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No		esidence 6 🗸 C	Other: Scene
	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28t	f. Location (Stre or Town, Stat		r Rural Route Number, City
	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.	e to the cause(se time, date an	s) and manner as d place, and due t	stated. to the cause(s)
20		29b. Signature and title of certifier 29c. License number O.C.M.E.	1.	9d. Date signed ebruary 26, 2	(Month, Day, Year) 2009
DX/s,	1	30. Name and address of person who completed cause of death (1em 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	1		
Sta Registr	te ar	31. Date filed (Month, Day, Year) NAR 0 3 2009 32. Begistrar's Signature MAR 0 3 2009			
DHMH 17 Rev 1/200		,			

DHMH 17 Rev 1/2001 OCME 2006

		1	For State Registrer		State	of Maryla	and / Dep	artmen			and M	_	giene	711114	06	375
		1	Decedent's Name (First, Midd	ile Last)				-			2. Date of De				ne of Death
Phys	ician		Marian Celeste									Month 2/25/2	Da OOO	y Year	5.0	00 P M
	dical		a. Facility Name (If not institution			umber)		4b. City.	Town, or	Location o	of Death	4/23/2		. County of Dea		70 F
Exan	niner		719 Maiden Cho					/		ville				Baltim		
Funer	al	_	Social Security Number	6. Se			rs. last birthday	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir (Month, Da	th Voor	9. Bir	thplace (Sta	ate or Foreign
Directo			216-30-8457	1]М 2 ДГ	74	Yrs.	Months	Days	Hours	Min.	6/21/1			cyland	
P		-	sual Residence of Decedent			1										
irylar show	_		Da. State 10b. Count	•		100.	City, Town or L								i	de City Limits Yes 2X No
Ba-f	Sto	L	MD Balt	1mo	re		Catons									
or 2		10	De. Street and Number		-			10f. Zip		•				tizen of What C	ountry?	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. wher then "natural", or Items 23a or 28a-f show ant, the Madical Examiner must be indiffed at	by Funerai Director	_	719 Maiden CHo	ice					2122		-:-0 /0	-it. V or No		JSA 14. Race - Am	oriona India	
er de	E e	1	1. Marital Status		Armed F		10.5.	If Yes, spec	ent of Hi	ispanic Origin, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.))-	Black, Whi		n,
36 rs aft	>		1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce		If Yes, G Year or	2 XNo live Dates:		1 🗆 Yes	2 X No	Specity:				Specify:	White	
21215-0036 od within 72 hours aff giene. er than "natural", or if the Medical Exam	pa	H	15. Decede			-	16a. Dece	edent's Usua	al Occupa	ation			16b. K	and of Business		
157 in 72	piet	L	(Specify only high		e completed		(Give	kind of wor DO NOT us	rk done d	during most	t of worki	ng				
212 with iene.	Completed		Elementary/Secondary (0-12)		College 1	(1-4or 5+)	Secr	etary					5	State Go	overme	ent
t Hyg	BeC	1	7. Father's Name (First, Middle	, Last)						18. Mothe	r's Name	(First, Middle	, Maider	Sumame)		
lar lenta fenta rked	To B		George Beinlie	n						Anna	Hele	en Goel	ler			
Baltimore, Maryland 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygione. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Modeal Examines must be notified at			9a. Informant's Name/Relation	ship (Ty	pe, Print)		19b. Mail	ing Address	(Street a	and Numbe	r or Rura	I Route Numb	er, City	or Town, State,	Zip Code)	
and 2 alth a stra			Julia A. Legar	de /	/ Daug	hter	824	1 Wate	ersio	de Co	urt,	Freder	ick,	, Maryla	and 21	701
Baltimore, permit. Pages 1 a Department of Hea Important: If Itam any injury or othe		2	Oa. Method of Disposition			L	. Place of Disp cemetery, cre	osition (Nan	ne of ther plac	e)		ate	20c. L	ocation - City or	Town, Stat	10
Page Page Int: If	.		1 ☐ Burial 2 💢 Cremation 1 ☐ Donation 5 ☐ Other (ayview (Cremat	ory		2/27/	/2009	Bal	timore,	Mary	land
alti mit. partri porta	9	2	1. Signature of Funeral Service	Licens	• ()90	\wedge							uner	al Home	, Inc	
m Fall	Suce		Selvan	G	Don	Ju	4	4107 W	ilke	ens Av	venue	e, Balt	imor	e, Mary	land	21229
Pnysicia /Medic Examine	al	1	23a. Pant1. Enter the disease, shock, or heart failure. Lis mmediate Cause (Final disease or condition esulting in death)	or complete only of	ne cause on a.	caused the deeach line. (or as a cons	etas					C - C		Llr		imate I Between and Death
3760, ate be executed hysician and the burial-transit	icai Examiner	o ct	sequentially list conditions, y so the sequence of the sequen	{	с	o (or as a cons	381-222									
, P.O. Box 687(that the death certificate to end by the attending physis detached for use as the to	Physician/Med	1 2	F FEMALE: :3b. Was decedent pregnant in the past 12 months? 1 □ Yes = 2 □ N o 9 □ Unknown	2	1 ☐Live	utcome of pre- birth 2 F gnant at time on	etal death 3	□Ectopic pr □ Other (sp						23d. Date of de Month	livery Day	Year
ecords, P.O law requires that the as been signed by th 2 should be detache	F.	P	art II. Other significant condit	ions co	ntributing to	death but not	resulting in the	underlying c	ause give	en in Part I.		23e. Did 1	obacco	use contribute t	o the cause	of death?
Records, The law requires te has been signed age 2 should be ear	Ω ا											1 🗆	Yes 2	□N0 3□P	robably 4	Unknown
cord require been s should	Completed	1										24a. Was	an	24h Were a	utonsy findir	ngs available
~ o = o	E	1-										auto	psy ormed?	prior to death?	completion	of cause of
				-1 1								1 Yes	2 NO	1 □ Ye	s 2□ No	
of Vital Physician: T this certificate ral director, pa	Be		5. Was case referred to medic examiner?		lospital:	31	C. C		Othe			(Check only		a 🗆 Out / O	-16.4	-
Of Phy ralig	tlon: To	1	1 Yes 2 No 7. Manner of Death 1 Natural 5 Pend 2 Accident inves	!_	28a. Date		28b. Time (-	8c. Injun Worl			me 5 Hesi 28d. Describe		6 □Other (Spenry occurred	ecity)	
Division al or Attending s after death. I Director: After d in by the fune	Certification:		3 ☐ Suicide 6 ☐ Could	-	28e. Plac buil	ce of Injury - A ding, etc. (Spe	t home, farm, s ecify)	treet, factory	, office			28f. Location (City or To	Street ai wn, State	nd Number or R e)	ural Route l	Number,
Divi To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (ner: On the) and manner a d place, and du		se(s)
To the within To the comp	¥		9b. Signature and title of certif	er g	Tyn	m	us	0	de	7VC		7	2	ite signed (Mon	09	
		3	0. Name and address of perso	n who co	17/	1/4.	argan	Print)	ne	Ca	14,	Colti	nsi	el 4, 4	42	1218
	State istrar	3	31. Date filed <i>(Month, Day, Yea</i>			Registrar's Si	gnature 	barke	1							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PIT, 25, per ME, 889 3/10/09 FTT and Mental Hygiene 2 0 0 Cortificate of Death 06376 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 15:35 M SPENCE GREGORY 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SAMARITAN HOSPITAL BALTIMORE, MID If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 6. Sex 1**M** 2□ F 19-58-201 Yrs. **Director** Dr. 22,1953 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Exa . incr must be notified at 1 es 2 No Director timore 10g. Citizen of What Country 10e. Street and Numbe Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Marital Status 1 □Yes No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes No ģ 3 Widowed 4 Divorced "natural" Completed event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CI 17. Father s Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be Item 27 Is marked other traumatic ev ၀ 19a. Informant's Name/Relationship (Typ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If It any Injury or o Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (So 21. Signature of uneral Se Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK, **Physician** UROSEPSIS /Medical Due to (or as a consequence of): Examiner COMPLICATED URINARY INFECTION, PHEUMONIA. 2days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) G. For Dr. Titus The law requires that the death certificate be executed signed by the attending physician and i be detached for use as the burial-tran CERTIFICATION APPROVED BY MEDICAL EXAMIN Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>ک</u> MALIGNANCY WITH UNKNOWN PANOYTOPENIA, 1 ☐ Yes 2 ☐ No 3 Probably 4 Vonknown Completed Site PRIMARY WITH VERTEBRAL 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate METASTASES PARAPLES A with resulting paraplegia Dyes 2 No 2 🗆 No 1 TYes Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 10 No 1 ☐ hpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of nours after death.

neral Director: After this
filled in by the funeral di this 27. Manney of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) maamayn SHIVAKUNAR NARAYAMAN RES-000. 20 09 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NARAYANAN, GIEDD SAMARITAN HOSP. 560) LOCH RAVEN BIND, BALTIMORE SHIVAKUMAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 03 2009 Registrar

Physician	
/Medical	
Examiner	

Funeral Director

ral", or items 23a or 28a-f show Examiner must be notified at death with Pages 1 and 2 should be filed within 72 hours after on nent of Health and Mental Hygiene. "natural", traumatic event, the Medical is marked permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra

Synodings James Baltimore, Maryland 21215-0036

Physician /Medical Examiner

certificate be executed burial-tran attending physician and the use as ō signed by the aid be detached to detached page 2 certificate within 24 hours after death.

To the Funeral Director: After this funeral or Attending

P.O. Box 68760.

Division or Vital Records,

06377 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 Synodinos 0854 A M James 0 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Baltimore Roscoale anklin Sauare Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Aug 15, 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 1940 Months Maryland 1**X** M 2□ F 68 Aug 219-38-1330 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County 1 ☐ Yes 2 ☐ No Director Baltimore Towson Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1142 Gypsy Lane East 21286 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Anthony John Synodinos Asimakes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Ruth L. Synodinos/ Wife 1142 Gypsy Lane East Towson, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. 3-5-09 Timonium, Md. 4 Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
RUCK Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licens complimions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, in shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final 3 day disease or condition resulting in death) Due to (or as a consequence of): carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ✓ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 2 1 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Many er of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D21846

Registrar

State

filled in by the

To the Hospital

Franklin Square Dr. Baltimore, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 06378 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year SPHANKLE SO PM 2 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SAWARITAN NY AUT HOSPITAL imode If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 X M 2 □ F 76 212-30-5368 October 6, 1932 Pennslyvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☑ No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 U.S.A. 546 Brook Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 👿 No Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Guidance Counselor</u> Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herbert Henry Sprankle Bertha Rosensteel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor A. Sprankle / Wife 546 Brook Rd., Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 02-28-2009 Towson, Maryland 21. Signature of uperal Service Licensee Ruck Towson Funeral Home 21204 1050 York Road, Towson, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ALLUME 342 PART ONGESTIVE disease or condition resulting in death) Due to (or as a consequence of): O RUN ARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of):

Physician /Medical Examiner

permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun Once.

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th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-1 shov traumatic event, its Madical Examinari wat by nuffied m

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-transit attending physician Physician/Medical as esn for the signed by a 2 page 2 should Completed certificate Be

Hospital or Attending Physician: The law requires that the death certificate be executed Apple Certification: To After

Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 10

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

R 0 3 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

that initiated events resulting in death) Last	c	quence of);			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. if yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopi	ic pregnancy (specify)		23d. Date of delivery Month Day Year
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				24a. Was an autopsy performed	
25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)	
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27. Manner Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, street, fact	tory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
29a. Certifier 1 ☐ CertifyIng Phy (Check only one) 2 ☐ Medical Exam	/sician: To the best of my kniner: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigat	red at the time, date and pla tion, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
29h Signature and title of certifier			29c License number	204	Date signed (Month Day Year)

29c. License number

JOU KLUB BACILIMONE

29d. Date signed (Month, Day, Year)

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Physi /Me	dical	Jean Strakes							Februar	y 26	2009	7:45	Рм		
Exan	niner	4a. Facility Name (If not institution 1424 Galena Roa		umber)		4b. City, Town, or Essex		Death			ity of Death				
Funer	eol .	5. Social Security Number	6. Sex	7. Age (In yrs. la	last birthday)	If Under 1 Year	If Under 24		8. Date of Birth		9. Birthi	place (State or F	Foreign		
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shoul and M s mar	욘	19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailin	ng Address (Street				r, City or Tow	ın, State, Zij	p Code)			
0 00 00		Christina Strak	es/Daugh			Fordcres	st Roa					21237			
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permit. Pages 1 and 2 Department of Health Important: If item 27 I any injury or other tra		4 □ Donation 5 □ Other (S	1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1 M Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1 M Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1 M Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1 M Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)												
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Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAR 0 3 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 155 AM Lichael 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) (In yrs. last birthday) 52 Yrs. **Funeral** 214-64-8636 Months Days 17 M 2□ F Director marylan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside €ity Limits Show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examiner must be notified at 1 Ves 2 No Director rna 10e. Street and Number 10g. Citizen of What Country Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 Divorced Completed Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) -oppers Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Laşt) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MoTho and to washing 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-4-09 270 m 21. Signature of Feneral Service Licenses 22. Name and Address of Facility not the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the disease, or complications that caused the death. 23a. Party. Enter. Approximate Interval Between Onset and Death Immediate se (Final disease or indition resulting in death) **Physician** SEP515 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transi and Due to (or as a consequence of) attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed After this certificate 1 Yes 2 | No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation Hospital or Attending 1 Natural after death.

I Director: Af d in by the fur 1 ☐ Yes 2 🗌 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar Hanh

31. Date filed (Month, Day,

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Year)

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2. Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3 2800 **Physician** 52 PM 03 Blanche Tomlinson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Wicomico alisbur at HOSPICE the Lake dastal If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours unk 1 □ M 2 🛱 F 11, 51 Aug Director 213**-**70**-**9654 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits fshow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2√ No Director MD Princess Anne Somerset 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21853 USA 11635 Beachwood Street Funeral un K₁₂. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white ģ 3 Widowed 4 Divorced Completed unk 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 31anche Coastal Hospice at the Lake 351 Deers Head Hospital Road Salisbury, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5♥Other (Specify) in state Sign ture of suneral Service icensee Ronal o Wade State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARCINOM RECTAL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes Æ□No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: 21 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of beath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🖾 Patural 5 Pending ours after death.

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To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARY HOSPICA COASTAL Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 03 2009 Registrar

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		For State Registrar	State o	f Marylan		artment of H rtificate of			lental Hy	giene Reg. No.	2000	n 6 3 8 3
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Funeral Director		5. Social Security Number 162-26-0443 Usual Residence of Decedent	6. Sex XX M 2□ F	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Oct. 10	rth av, <i>Year)</i> 6, 19	9. Birthp Cour Penns	place (State or Foreign htry) Sylvania
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may hiptry or other traumatic event, the Modical Examiner must be rotified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Marri 3 □ Widowed 4 □ Divorced	12. Was Dece Armed Fo	cedent Ever in U.S. orces? 2 □ No sive 13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri				ecify Yes or No Rican, etc.)	1	4. Race - Americ Black, White, Specify: Wh	etc.	
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and 2 shou lealth and M m 27 is man	-	19a. Informant's Name/Relationsh Marilyn Walsh T		fe		ng Address <i>(Street</i> 4 Harding	and Numb	er or Rura	al Route Numb	er, City or		Code)
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		30. Name and address of person v	MDo 5	se of death (Item	23a) (Type,	Print) LANG	e, C	ol	in E.	4,1	40 21	1044
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			For State Registrar		State o	f Maryla	nd / Dep <i>Ce</i>	artment <i>rtificate</i>				lental H	ygiene Reg. No	2000	3 06	384
	Physici	ian	1. Decedent's Name		,							2. Date of D Month	Da			e of Death
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	4	Н	5. Social Security Nu	nes H	ealth i	Care		If Under 1	200	It Under	TOYE					
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036	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Than "natural", or items 23a or 28a-f show ent, the Medical Eracinat must be confined at	Completed by Funeral Director	1 ☐ Never Marrie 3 ☐ Widowed 4	_		2 ⊠ No ⁄e		1 □ Yes 2		Specify.		,		Specify: Wh		
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.			Cremation 3	Removal from S	olate	Place of Dispo cemetery, crei lantic				3/6/2	ate 2009		ocation - City or en Burn		
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्ट्रें हिंदु	requires een sign nould be	ted b	mort	bid obesin	dy							1 🗆	Yes 🗡	5.N 0 3□P	robably 4] Unknown
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ita	sician: The law certificate has t irector, page 2 sl	Be Co	25. Was case referred examiner?	d to medical						26. Place	of Death	1 ☐ Yes (Check only o	2 No	1 □ Yes	2X No	
25	Physic r this c		154 Yes 2 □ No 27. Manper of Death	0			R/Outpatier			4 📖 190				6 ☐ Other (Spe	cify)	
Pion	ending sath. or: Afte he fune	ation	Natural 2 Accident	5 Pending investigation	on	f Injury n, <i>Day, Year)</i>	Injury	м	injury Work? 1 □ Y	? ′es 2 ∐ 1	- 1	8d. Describe	now injur	y occurred		
Division	I or Att after de Directe	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 28e. Place of building	of Injury - At h g, etc. <i>(Speci</i>	ome, farm, stro fy)	et, factory, o	office		2	8f. Location (City or To	Street an wn, State	d Number or Ri	ural Route Nu	ımber,
	tospita t hours uneral		29a. Certifier (Check only	Certifying F	Physician: To the aminer: On the ba	best of my kno	owledge, deatl	occurred at	the tim	e, date an	id place, a	and due to the	cause(s)	and manner a	s stated.	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	one) 29b. Signature and titl	le of certifier	completed cause	er stated.		29c. L	_icense	number	an occurre	ou at the time,	29d. Dat	e signed (Mont	h. Dav. Yearl	
	->-O		-	47	Checkley	1 WI	7		26	9916	795			February	28	
(6)	H		30. Name and address	s of person who	completed cause	of death (Iter	n 23a) (Type, I	Print)	vehi	re l	salt'	nene n	1ans	and 217	29	
	Stat		31. Date filed (Month,	Day, Year)	32. Re	gistrar's Signa	ature			- 7					- /	
	Registra	ar	MAR	U 3 2009	Reneral	B.	park									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 24, Frances Taylor February 2009 10:18 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gwynn Oak 5928 Montgomery Street 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 🕱 F 82 Director 216-30-7716 Oct. 1926 Germany 13, Usual Residence of Decedent filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must by nothing at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Gwynn Oak 1 ☐ Yes 2 XNo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 USA 5928 Montgomery Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: Completed by Specify: 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Hotel Manager marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H tem 27 Is marked oth Be Johann Stumpf Franziska Hartl ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Keller Daughter 9030 Furrow Avenue; Ellicott City, MD 21042 item 27 other to Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 ment of H permit. Pages Department o Important: If i any injury or = 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/2/2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke uneral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 201 /Medical a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be execute the attending physician and ned for use as the burial-trar the burial-train that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months: 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably page 2 should After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 \sum Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manuar of Death funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation nours after death.

neral Director: A filled in by the fu death. 1 □ Yes 2 No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check one) and manner stated. 29b. Signa ure and title of certife 29d. Date signed (Month, Day, Year) who completed cause of geath (Item 23a) (Type, Print Marce loverne W in 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Scott Taylor 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan . 18,1928 5. Social Security Number Birthplace (State or Foreign Country) MD 7. Age (In vrs. last birthday) Months 1 □ M 2 🔀 F 81 096-24-9165 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ZYes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4515 Valleyview Ave. 21206 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Nursing Aid Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Scott Mable Scott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ada Taylor/ Daughter 5513 Edna Ave. Balto. Md 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Cemetery 4 ☐ Donation 5 ☐ Other (Specify) March 5, 2009 Balto.MD 21. Signature of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD 21213 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACIDOSIS disease or condition resulting in death) Due to (or as a consequence of): FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year specify) 23e. Did tobacco use contribute to the cause of death? cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the once.

Physician /Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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d other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at

Maryland 21215-0036

Baltimore,

Examiner Physician/Medical þ Be Completed

Certification: To

Medical

burial-trans for use the has been signed by e 2 should be detacl funeral director, page 2 should certificate this After To the Hospital or Attend within 24 hours after death To the Funeral Director:

Physician: The law requires that the death certificate be executed

Hospital or Attending

filled in by

completely

Division of Vital Records, P.O. Box 68760,

1 ☐ Yes 2 ☐ N o 9 ☐ Unknown	9 Unknown	5 ∐ Other (s
nt II. Other significant conditio	ns contributing to death but not resulting in t	he underlying
	_	

	25. Was case referre examiner? 1 ☐ Yes 2 ☐ N	
I	27. Manner of Death	"
ı	1 ☐ Natural 2 ☐ Accident	5 Pending investig

1 Hnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) tigation 6 ☐ Could not be

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 🗌 No

2 40 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify)

29a. Certifier (Check only one)	1 ☐ Cei 2 ☐ Me	

3 Suicide

4 Homicide

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) fying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

cal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

9b.	Signature	and title	of ce	rtifier
		3	2	1

determined

29c. License number RESODO

HOSPITAL BALTIMOR

26. Place of Death (Check only one)

5601

Registrar

31. Date filed (Month, Day, Year)

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- SARAFUA FLEWA: GOOD SAMARITHN

09-01643 Nikoletta Balogh Trinite

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	,	Certific	ate of	Death		· ·	Reg. I	No.		
Physicia Medical Exami	ın/	1. Decedent's Name (First, Midd Nikolett		Trinite	3				e of Death oth Da ruary 25,	3009 2	10 0 9 me of	38
15.00		4a. Facility Name (if not institution Deer Park Resevoir				b. City, Town, or L Finksburg	ocation of Dea		ruary 20,	4c. County Carroll		
Funeral Director		5. Social Security Number 218-79-6262	6. Sex 7. Ag	e (In yrs. last birt	thday) Yrs.	If Under 1 Year Months Days	If Under 24H Hours M	/lin.	ate of Birth (N $5/15/1$		y) 9. Birthplace (Sta Country) Hunga	
any,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location	on					10d. Inside	City Limits
* .	ţ		roll	Syl	kesvi				140-	0:4:		2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 1108 King Ar	thur Court			10f. Zip Code	1784		10g.		hat Country?	
5-U036 ed within 72 hours after death with the Maryland tygiene. offier than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	y Funeral	11. Marital Status 1 Never Married 2 X N 3 Widowed 4 Dir	12. Was Decedent Armed Forces? 1 Yes 2. vorced If Yes, Give Year or Dates:		If Ye	s Decedent of Hispes, specify Cuban, Yes 2 X No	Mexican, Pue				e - American Indian, te, etc. White	Black,
5-U036 led within 72 hours a tygiene. other than "natura the Medical Examin	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	College (1-4 or	5+)		's Usual Occupationst of working life.			ne 16		usiness/Industry	
5-00% led with tygiene officer the		17. Father's Name (First, Middle	e, Last)			1	8.Mother's Na	me (First,	Middle, Maid			-
21215- 1d be filed Jental Hyg narked off	Be Be	Pal Balogh 19a_Informant's Name/Relation:	shin (Type Print)	119	h Mailing	Address (Street			arkas	City or To	wn, State, Zip Code)	
MD 2 d 2 shou lth and M u 27 is n	၉	John G. Trini 20a. Method of Disposition		and 1	1108	,	hur Co		Sykes	ville,	MD 21784	
			n 3 Removal from Sta	ate cremat	tory or oth			3/2/0			tead, MD	
Baltin permit Departin Importa		21. Signature of Funeral Service	Licensee			ame and Address	•	,			erstown R	
Physician /Medical		23a. art I. Enter the disease, o failure. List only one cause	r complications that caused on each line.			ine Fune e mode of dying, s		ic or respir	ratory arrest,	shock, or he	eart Approxin Between	. 136 nate Interval n Onset and Death
Examiner		 Infimediate Cause (Final disease or condition resulting in death) 	Due to (or as a cons							All,	٠.	
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cuted ind transit		events resulting in death) Last	Due to (or as a conse	equence of):		_					T ₄	
760, icate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED									
Box 68760, edath certificate be the attending physical for use as the burned for use as	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Ur	4 Pregnant at		2 Fet	al death 3	Ectopic pre	gnancy		23d. Date of Month	of delivery Day	Year
, P.O. B rres that the de signed by the	d by Phy	Part II. Other significant condi	tions contributing to deat	th but not resultin	ng in the u	nderlying cause g	iven in Part I.				Probably 4	
Division of Vital Records, P.O. Box 68'. To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Fungral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed							-	4a. Was an autopsy performe ✓ Yes 2	ed?	Were autopsy finding prior to completion of death? 1 Yes 2	
Vital Rec ysician: The his certificate	BeC	25. Was case referred to medical examiner?	Hospital			1	of Death (Che					
ding Physic After this	ျ	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Ini	ury 28b	outpatient Time of Ir	3 DOA	y at Work?	rsing Hom 28d. [e 5 Res		Other: Scene	
Division can or after ding rs after death. In Director: After din by the fun	Certification:		FOUND: Day, Vinding Feb 25, 2009	FOU 142	JND: 5 hrs		'es 2 ✓ No		ect shot s		ber or Rural Route N	lumbor City
Divi:	Certifi	4 Homicide dete	ald not be (Specify) car		ami, stree	et, factory, office b	unding, etc.	0	r Town, State	e)	Reservoir, Finksbu	
To the Hospital within 24 hours To the Funeral completely filled	Medical		Physician: To the best of mainter: On the basis of exa and manner stated.									
	ž	29b. Signature and title of certification (1995)	er 1.1.1.1	K	1	29c. License O.C.N			i i	9d. Date sig February :	ned <i>(Month, Day,</i> Ye 26, 2009	ar)
		30. Name and address of perso Zabiullah Ali, M.D.	Assistant Medical E	xaminer 1	11 Pen	n Street, Balti	more, MD	21201				
St Regist		31. Date filed (Month, Day, Year,	2 2009 32. Revistra	ar's Signature	p	all						
		131111	-		mp-s ^{de}							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06388 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 3:47 PM Gary H. Vaughn 28. February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis
If Under 1 Year If Under 24 Hrs. Anne Arundel 1757 Broadlee Trail 9. Birthplace (State or Foreign Country)
Pennsylvania 5. Social Security Number 8. Date of Birth (Month, Day, Sept 22 7. Age (In vrs. last birthday) **Funeral** Year) 950 Days 1 X M 2 □ F Months Hours Min Sept 58 Director 500-52-6618 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√☐ No Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** 21401 Funeral 1757 Broadlee Trail 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Demo Charles Vaughn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Vaughn, Wife 1757 Broadlee Trail Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 103/02/09 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service License
Thomas Gregor cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 18 months **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗀 Ectopic pregnancy signed by the atte Month Dav Year Pregnant at time of death 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page this certificate 2 No 1 ☐ Yes 2 No 1 ☐ Yes Hospital or Attending Physician; filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation Accident 1 ☐ Yes 2 ☐ No 24 hours after deatl Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOS7936 Name and address of person who completed cause of death (Item 23a) (Type, Print) Us 225 Creene St- Boutimore Mb 21201. Heather D Manuel 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month John William Wrench February 2009 3:40 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Hampton Manor Frederick Frederick If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year Oct 13, 19 Birthplace (State or Foreign Country)
 New York 7. Age (In yrs. last birthday, **Funeral** Months 213-38-4666 1**∑** M 2□ F 97 Director Oct 1911 Usual Residence of Decedent 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be refilled at Director 1 ☐ Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 102 Mt. Olivet Blvd. USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Mathematician U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Louise Brown John William Wrench, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance P. Wrench, Wife 102 Mt. Olivet Blvd. Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. | 02/28/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service License Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical attending properties for use as as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. □Yes 2□No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy page or Attending Physician: The certificate 1 ☐ Yes 2: No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After th funeral 27. Manner of Death Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation ours after death.

neral Director: Al
filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated

State Registrar 29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Physician /Medical **Examiner** Examine

Department of Health a Important: If item 27 is any injury or other traionca.

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

Sama

eaver

rsician and ร burial-tran by Physician/Medical Certification: To in 24 hours the Funeral Directory filled in

Be Completed

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Binh

30. Name and address of person who

NG/UYEn/MO

WAR 0 3 2009

resulting in death) Last	Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	23d. Date of delivery Month Day Year
Part II. Other significant condition	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown
		24a. Was an autopsy performed? 1
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hol	me 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injury 28b. Time of Injury at Work?	28d. Describe how injury occurred
3 Suicide 6 Could no 4 Homicide determin		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Physician: To the best of my knowledge, death occurred at the time, date and place, xaminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	

29c. License number

D0065094

Square DR Baltimore md

29d. Date signed (Month, Day, Year)

State Registrar

within 2.

completed cause of death (Item 23a) (Type, Print)

9000

FRANKLIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #26, perMD, g889 3/3/09 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Horace Christopher Wilton Feb 200 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore N/A 319 Ilchester Ave If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□ F 216-42-9862 65 Director VΑ Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A MD Baltimore Funeral Director 1 TyrYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 319 Ilchester Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 □ No If Yes, Give Year or Dates: 1970 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status th and Mental Hygiene.
?? is marked other than "natural", or item traumatic event, the Medical Executors. 1 Never Married 2 Married Specify frican 3altimore, Maryland 21215-0036 1 □Yes 2 No Completed by Specify: 3 Widowed 4 Divorced American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Correction Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julian D. Wilton Maggie M. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any injury or other trau Sharlee Wilton/Daughter 319 Ilchester Ave, Balt., MD 21218 20b. Place of Disposition (Name of Cemetery, crematory or other place)

Bayview Crematory 2/19/09 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. Close F. Svs., PA 21. Signature of Funeral Service Licensee 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be exe Box 68768 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed: 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Medical Certification: To Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1- Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the f within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number ロタタナノナ 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 = 5 31. Date filed (Month, Day, Year) State Registrar

Physician

/Medical

Director

Completed

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Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

completely filled in by the funeral

within 24 hours a To the Funeral I

Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Patricia Ann Willis March 1:30 A M 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Manorcare of Dulaney Baltimore Towson If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2**X**F 215-32-8083 78 January 4, 1931 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Baltimore Towson 1 ☐ Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 409 Virginia Ave. United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🂆 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Benton Mecaslin Margaret Elizabeth Mathias 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Charles Willis/husband 409 Virginia Ave. Towson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park Mar. 5,2009 4 ☐ Donation 5 ☐ Other (Specify) Parkville, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. Raltimore. MD 21212 21. Signature of Funeral Service Licensee 23a. 7a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐No 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RTERY DISFASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

29a. Certifier

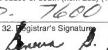
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number D-12849

29d. Date signed (Month, Day, Year) 03-02-09

5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A.H. GHLADI, MD. 7600 OSLER DV. TOWSON MD 21204 A.H. GHLADI MD. 31. Date filed (Month, Day, Year) State



Registrar

WILLIAMS MAMONE 09-01568 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 06393 Certificate of Death Reg. No Registrar Physician/ Decedent's Name (First, Middle,Last) 2. Date of Death Month Day February 22, 2009 Williams 2127 hrs **Medical Examiner** THOUL MOD 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number . County of Death Sinai Hospital N/A Baltimore 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Hours Min Director Months Davs 097-76-04 М Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 No or 28a-f show notified at once. altimore Director 10e. Street and Numb 10g. Citizen of What Country malee Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married No Yes If Yes, Give Year Yes 2 No Widowed Divorced specify Specify: þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 72 event, the Medical 21215-0036 Pages I and 2 should be filed within I hent of Health and Mental Hygiene. Int: If item 27 is marked other than is marked other than Sales 18. Mother's Name (First, Middle, Ma Be Williams 19b. Mailing Address (Street and Number 9 Baltimore, In permit: Pages I and 20b. Place of Disposition (Name of ce crematory or other place) 2 Burial Cremation Removal from State 116/09 Important altimure, MM Department Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service License Physician ntenthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardial or respiratory arrest, shock, or heart Approximate Interval Between Onset and nly one cause on each line /Medical a Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical attending physician or use as the burial -UNPENDED **AMENDED** that the death certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? ş Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? After this certificate Yes 2 1 🗸 Yes 2 25. Was case referred to medical To the Hospital or Attending Physician: 26.Place of Death (Check only one) Division of Vital Be examiner? Inpatient 2 V ER/Outpatient Nursing Home 5 Residence 6 Other 1 ✓ Yes 28a. Date of Injury Feb 22, 2009 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Medical Certification: Subject shot 2058 hrs Natural Yes 2 V No I Director: ed in by the f Pending within 24 hours after death. Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 2400 Loyola Northway, Baltimore, MD Funeral 4 V Homicide (Specify) Parking Lot 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 and manner stated 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year)

MAR 0 3 2009

Patricia Aronica-Pollak MD.

and address of person who completed cause of death (Item 23a)

OCME

ORIGINAL

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

February 23, 2009

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Month Year Williams 304 M ,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Himore Washington Burn MANNY model Med. Ctr. If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits or items 23a or 28a-f show Injury or other traumatic event, the Michael Examiner must be notified at 1 ☐ Yes 2 No MD evern Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21144 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No Specify: à 3 Widowed 4 □ Divorced Blac "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na.
any injury or other traumatic events." (Give kind of work done during most of working life. DO NOT use retired) condary (0-12) College (1-4or 5+) Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Williams ၉ Snowden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) oan M. Strauther Queenstown Rd. Severn Davanta MO 21144 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition Date Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Green - aneral SI Meen 23a. Part 1. Enter tife disease, or complications that caused the death. Do not enter the mode of dying, shock, or healt failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, in a first time clate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending in 24 hours and the Funeral Director; Af 1 □Yes 2 Accident investigation 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature nd title of cert 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signa

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 10:00 P M 2/24/2009 Wilbur A. Watts /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carrol1 Lorien Assisted Living Mt. Airy If Under 1 Year | If Under 24 Hrs. 5. Social Securify Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1X M 2 □ F Yrs. 100 **Director** 213-05-9107 12/12/1908 MD Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MD Carrol1 Marriottsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6829 Ridge Rd. 21104 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify: White þ 3K Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) 8 Power House Operator Transit Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F Oliver Watts Willimina Klemn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any inlury or other trau
once. Nancy Marie Ely/Daughter 6829 Ridge Rd., Marriottsville, MD 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 100 Rurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lake View Mem. Park 3/2/09 Sykesville, MD 21. Signature of Funeral Burried Ad Queen Tuneral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Advanced Age with Failure to Thrive month disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Hypertension with edema yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examine The law requires that the death certificate be executed Osteoarthritis yrs Due to (or as a consequence of): physician a the burial-1 Division or Vital Records, P.O. Box 68760, Physician/Medical Anemia yrs 33 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ gait disorder, glucoma, blindness 1 ☐ Yes 2XXNo 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No atrial fibrilation has e 2 1☐ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Machine (Specify Assist Living 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation Injury 1 🔀 Natural 1 ☐ Yes 2 ☐ No after death.

| Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a. Certifier 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signardin and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) D54749 Feb. 25, 2009 (Item 23a) (Type, Print) 30. Name and address of person who completed cause of 4 East Rolling Crossroads, Ste. 307, Baltimore, MD 21228 Allen Reilly, M.D. 32. Registrar's Signature 31. Date-filed (Month, Day, -Year) State Registrar MAR 03 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 9:56 a^M Donald Hugh Whitehurst 27, 2009 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Churchville 309 Windsor Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min Days 1 XM 2 ☐ F Director 212-30-1979 Apr. 28, 1931 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Example at a routhed at 1 □ Yes 2 X No Director Harford Churchville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 309 Windsor Court 21028 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Tyes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Retail Sales Owner/Operator Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Harry Winchester Whitehurst Margaret Ann Manner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Della B. Whitehurst / Wife 309 Windsor Ct., Churchville, MD 21028 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gd. 3-3-09 Timonium, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon, MD 21009 21. Signatury of Funeral Service Fice & e 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LHRONIC OBSTRUCTIVE Pulmonary ten years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of). Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 1 ☐ Yes 2 X No 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 🛣 Natural 5 Pending investigation after death.

I Director: Af in by the ful 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year)

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of Vital Records,

Division

NORTH

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

2355

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 State of Maryland Department of Health and Mental Hygiene 06397 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Wills Jacque Leonard 2009 12:57 PM February 23, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 8778/1918 Mary land 720-16-7060 1 X M 2 D F 90 Director Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location show 10d. Inside City Limits iral", or items 23a or 28a-f shov LEverniner must be notified at Director Lutherville 1 ☐ Yes 2 No Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21093 146 Westbury Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian 1 □XYes 2 □ If Yes, Give Year or Dates: o. 1 Never Married 2 X Married 2 | No Marylahd 21215-0036 1 □Yes 2 XNo Specify: Specify: White ≥ 3 Widowed 4 Divorced d other than "natural", event, the Medical Eve WWII Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland Stateottery 1 and 2 should be filed within Health and Mental Hygiene. permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Inc. M. any injury or other traumatic event, Inc. M. any once. Elementary/Secondary (0-12) 2 College (1-4or 5+) Sales 18. Mother's Name (First, Middle, Maiden Surname)
Marquerite Blackiston 17. Father's Name (First, Middle, Last) Be Leonard Agustus Wills ည 19a. Informant's Name/Relationship (Type. Print)
Lillian D. Wills/ Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 146 Westbury Road Lutherville, Maryland 21093 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
Dulaney Valley Mem. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/26/2009 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions Examiner equence of) d any, leading to miniociac cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be execute Due to (or as a consequence of) attending physician Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav Pregnant at time of death 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 □ No director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occupred Fell out of 1 Natural 5 Pending Bed_ 2 Accident
3 Suicide investigation 6 Could not be determined Location (Street and Nymble City or Town State) 515 filled in by 4 Homicide Bright ield Ro Living 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29d. Date signed (Month, Day, Year

Division of Vital Records, P.O. Box 68760, Hospital or Attending within 24 hours after deatl To the Funeral Director; completely

> State Registrar

10

29b. Signature and title of

31. Date filed (Month, Day, Year)

30. Name and add

DHMH 17 Rev 1/2001

ed cause of death

32 Registrar's S

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For amend item 8 per fn 8891 5-4-09 vt

Certificate of Death

Reg. No. 2 | 1 | 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22 2009 Physician FEBRUARY WEINSTEIN **ISADORE** 5:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MONTGOMERY SILVER SPRING RENAISSANCE GARDENS Birthplace (State or Foreign Country)
 CT If Under 1 Year | If Under 24 Hrs. 8. Date 6 Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Yrs 381-03-7041 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other traumatic event, the Medical Evandment rust be notified at 1 □Yes 2 X No Director SILVER SPRING MONTGOMERY MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or USA 20904 3160 GRACEFIELD ROAD Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Dayes 2 □ No
If Yes, Give
Year or Dates: ARM 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. and 2 should be filed within 72 hours after WWII 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 🕅 No þ 3 X Widowed 4 ☐ Divorced ARMY Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOSPITAL ADMINISTRATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **PEARL** GOLDSTEIN WEINSTEIN ISRAEL မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 is 1906 BILLY BARTON CIRCLE, REISTERSTOWN, MD DAVID WEINSTEIN / SON Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP 02/27/2009 TOWSON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred if or Attending F after death. Injury 1 Aatural 5 Pending No tine ...
Within 24 hours after use...
To the Funeral Director: Aft investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2009 00036716

DHMH 17 Rev 1/2001

State Registrar MAdrew

31. Date filed (Month, Bay, Year)

Gracefiel Rd. Silver Spring.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

3110

Kunderl

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination of the modified at once.

Physician /Medical Examiner

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

		•		ate of Dea		Mental Hy	Reg. No	0.0	00 0630
1. Decedent's Name (First, Middle,	Last)					2. Date of De	eath	4 U	3. Time of Death
John Yuha	nick					Febru	ary	^y 27,	2009 9:45 a
4a. Facility Name (If not institution,	give street and number,		4b. Ci	ity, Town, or Loca	ation of Dea	ath	4c.	. County o	
Stella Maris				<u> Pimoniu</u> der 1 Year If U	1M Inder 24 Hr				imore
286-44-1725	12KDXM 2□ F	ge (In yrs. last bii 59	Yrs. Month		ours Mir		ay, Year)		Birthplace (State or Foreign Country)
Usual Residence of Decedent		39				10/0/1	747		OH
10a. State 10b. County		10c. City, Tow		144					10d. Inside City Limit
		<u> </u>		ltimore					1 X Yes 2 □ N
10e. Street and Number	rlog Stroot	- No. 1		Zip Code					hat Country?
4000 North Cha	12. Was Decedent	<u>-</u>		21218	ic Origin? /	Specify Vas or N		USA	- American Indian.
1 ☐ Never Married 2 ☐ Marrie	Armed Forces? d 1 ☐ Yes 2 X					Specify Yes or Norto Rican, etc.)			, White, etc.
3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ∐Yes	2 XNo Spe	ecify:			Specify:	White
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Elementary/Secondary (0-12)	College (1-4or	5+) .		use retired) Relation				Δάνο	ertising
1 Z 17. Father's Name (First, Middle, La			_ WIIC			ame (First, Middle	Maidon		
John Joseph Yuh	,			1	Evely	•		Surrame,	,
19a. Informant's Name/Relationshi		19h	o. Mailing Addre			Rural Route Numb		or Town S	State Zin Code
Todd Yuhanick /	,					altimore	_		
20a. Method of Disposition			of Disposition (Nary, crematory of			Date			city or Town, State
1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		1 -	t Crema		2/3	28/2009	Har	nover	· MD
21. Signature of Funeral Service Li	Porota M		22. Name	and Address of F	Facility			ICVCL	, I.D
¿i) onate	2 Mous	liall	l raty	land Cre	ematio	on Servio	ces		
		3	I Po B	0x 1413.	. Balt	imore. N	$\sqrt{10}$ 21	1203	
23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused bly one cause on each li	the death. Do ne.	not enter the m	OX 1413, lode of dying, suc	. Balt	imore, N	MD 21 rrest,	1203	Approximate Interval Between
shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on each li	ne.	not enter the m	OX 1413, ode of dying, suc	. Balt	imore, N	MD 21 arrest,	1203	Approximate Interval Between Onset and Death
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shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, farly, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. LUNG C. Due to (or as b Due to (or as c Due to (or as d 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	ANCER a consequence of a consequence of pregnancy	of): of):	ode of dying, suc	. Balt	imore, N	rrest,		Interval Between Onset and Death
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State Registrar JACKIE JONES,
31. Date filed (Month, Day, Year)
NAR 03

VALLEY RD.

TIMONIUM, MD 21093

2300 DULANEY

32 Registrar's Signatus

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) Date of Death Month Day Year Hilda E. Yost 1504 2009 FEBRUAR 27 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE AGNES HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta Country) April 23,1922 Maryland 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 🖾 F 218-12-5085 86 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1XYes 2 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 849 Glen Allen Drive 21229 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 XNo Specify. Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Frye James Mackey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5911 Robindale Road; Catonsville, MD 21228 Laura Yost Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 3/3/2009 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee 1101490 Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK WEEK disease or condition resulting in death) Due to (or as a consequence of): PYELONEPHRITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last VRETEROLITHIASIS Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 5 Other (specify) 9 Unknown 9 Unknown

/Medical Examiner attending physician and for use as the burial-tran P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

iral", or items 23a or 28a-f shov Examiner must be notified at

"natural"

d other than "nature event, the Medical

of Health and Mental Hygiene.
If Item 27 Is marked other than
or other traumatic event, Ire M

Department of Health Important: If Item 27 any Injury or other troone.

Physician

Directo

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine Physician/Medical After this certificate has been signed by the funeral director, page 2 should be detached <u>۾</u> Completed Attending Physician; Be Certification: To To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Records,

Division of Vital

Part II. Other significant conditions o	ontributing to death but not res	ulting in the underlyin	g cause given in Part I.		se contribute to the cause of death? No 3□ Probably 4□ Unknown						
				24a. Was an autopsy performed? 1 □ Yes 2 ► No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ♠No						
25. Was case referred to medical examiner?	26. Place of Death (Check only one)										
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
27. Manner of Death 1. Natural 5 □ Pending	Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Description				occurred						
3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier 12*Certifying Ph	ysician: To the best of my kno	wledge, death occur.	red at the time, date and place	e, and due to the cause(s)	and manner as stated.						

29b. Signature and title of certifier

(Check only

Medical

State Registrar

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

BALTIMORE

MD

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062

21229

20. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 (ATOH MD

31. Date filed (Month, Day, Year)

MAD US SUUO

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 2 ebron Mitchell 24 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under Months Days Hours 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex 1 M 2 ☐ F ^{Year} 1924 **Funeral** 15, Maryland 217-12-9123 84 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Baltimore 1 Yes 2 No N/A MDDirector ms 23a or 28a-f s must be notified 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code United States 21231-3493 701 South Ann Street Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces?

X Yes 2 □ No 194 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or ite any fijury or other traumatic event, the Medical Examiner once. 1942 1945 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give þ 3 Widowed 4 XDivorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cargo Shipping Merchant Marine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Veronica Micolajcak James Zebron ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 214 Westshire Road, Baltimore, MD 21229 Jacqueline Liberto - Caregiver 20b. Place of Disposition (Name of MALVE PARCHA VELETAMS) 20c. Location - City or Town, State bod of Disposition 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State Cemétery @ Crownsville 3-3-2009 Crownsville, MD S ☐ Other (Specify) 4 Danation Frame and Address of Facility Ambrose Funeral Home, Inc. e of Fune al Service Lice 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Due to (or as a confiquence of): Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Vear Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 √ No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an formed7 2 √ No 1 ☐ Yes 2 🗌 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Marther of Death 1 🗹 Natural 5 Pending investigation Injury 1 Yes 2 No neral Director: At filled in by the fi 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) within 2 To the 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year) 32 MAR 0 3 2009

Jord

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

back

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February

600 North Wolfe St, Baltimore, MD, 21287

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Rea No 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 11 55 AM Mazie Blanche Zimbro 2 24-2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUARE HOSPITAL CENTER Rosedale If Under 1 Year | If Under 24 Hrs. Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🛱 F Months Days Hours 82 Director 212-22-2985 1926 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be neithfind anong. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Harford Abingdon 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral [21009 3510 Thomas Pointe Court, #2-D U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☑ No Specify: ģ White 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Crossing Guard Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Howard Singleton Blanche Widerman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Bennett / Daughter 8130 Rose Haven Road, Baltimore, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03-02-2009 | Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Furteral Service Licensee 1050 York Road, Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 15ch emic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Sequentially list conditions, if a year of the list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine HyperTention
Due to (or as a consequence of): attending physician and for use as the burial-tran Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should ! 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has trector, page 2 s autopsy performed? 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☑ No nous after death.

neral Director: After this certificat
y filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 ₹No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours a

To the Funeral C

completely filled

Baltimore, Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and ite of certifier

29c. License number D53462

29d. Date signed (Month, Day, Year)

ess of person who completed cause of death (Item 23a) (Type, Print)

mune 9000 FRANKLIN Square DR Balto md 21237 S 25 31. Date filed (Month, Day, Year)
MAR 0 3 2009 32. Registrar's Sig

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** oma /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 ☑ M 2 ☐ F 216-52-7577 Director 59 11-16-1949 MD. Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedfeal Evantise must be putilled at once. 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Carroll 1 √Yes 2 No MD Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 Timber Ridge Dr., POB 1443 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2√☐ No Specify. Completed by Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Door Guard accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmo Thomas Albaugh (Osborne) Norma ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina N. Brundick, niece 28 Liberty St., Apt. 208, Westminster, Md. 21157 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. State 1 Burial 2 Cremation 3 Removal from State 2/13/2009 Carroll Cremation Hampstead, Md. 21074 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00741 22. Name and Address of Facility Eline Funeral Home Lemmer 934 South Main St., Hampstead, Md. 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MULTIORGAN SYSTEM FAILURE Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): DIFFICILE COLITIS Examiner LOSTRIDIUM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ END-STAGE RENAL DISEASE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate perform Division of Vital 1 ☐ Yes 2 ☐ No 1 □Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) After 1 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Hospital or Attending Natural 2 Accident 1 ☐ Yes 2 ☐ No completely filled in by the 24 hours after deat Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30263 NSL 2-12-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200 MEMORIAL AVENUE

200 MEMORIAL AVENUE 3 WESTMINSTER, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature parker Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. N2. [] 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ZCAMU 1106 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Ye Jan. 21, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Year) 1929 **Funeral** Min. 1 □ M 2 🗷 F Months Days Hours 218-26-8745 80 Jan. Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Anne Arundel Maryland 1 Yes 2 No Annapolis Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 931 Edgewood Rd. 302 21403 Completed by Funeral Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 HNo Baltimore, Maryland 21215-0036 'natural', or Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event, the Medical Expone. 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Klein Charles Genevieve Coffay ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 931 Edgewood Rd. #302 Annapolis,MD. 21403 Anthony Alcamo 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 2/17/2009 Crownsville, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home f Funeral Servi 2973 Solomons Island Rd, Edgewater, MD. 21037 23a. Part 1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to ler as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jesse of Ju y that initiated events resulting in death) Last Due to (or as a consequence Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal deat 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 Z No 9 ☐ Unknown signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🗔 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No death. Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direc 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) Signature and title of certifier 29b

Registrar

180

State

30./Name and address of person who

31. Date filed (Month, Day

completed cause

death (Item 23a) (Type, Print)

N

Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 0156 AM 2009 Donyal Yvette Addison Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 8. Date of Birth | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗙 F Director 220-80-9834 40 13, 1968 Maryland Feb Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Director MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 Lincoln Avenue 20850 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after on eath and Mental Hygiene. n 27 is marked other than "natural", or iter 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Bus Attendant Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Benjamin Franklin Brunner Ernestine Schools 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other trac Ernestine Schools/Mother Frederick Ave., Rockville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation Riverdale Crematory 2/13/09 Riverdale, MD 21. Signatu meral 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street, N.W., Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line.

Immediate Cruse (Final disease or condition resulting in death)

a. At the succession of the death of **Physician** fais /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed Box 68760, burial-trag Due to (or as a consequence of) Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, Completed by 1 ► 🗸 s 2 🗆 No 3 🗆 Probably 4 🗇 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 P/Outpatient 3 DOA 1 Inpatient funeral 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: /
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospitai The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Nicole S.

29b. Signature and title of certifier



ted cause of death (Item 23a) (Type, Print)

30. Name and address of person who comp

29c. License number

Center Drive, Rockville, MD

29d. Date signed (Month, Day, Year)

20850

State of Maryland / Department of Health and Mental Hygiene

		Cer	tificate of Death	Reg. No. 0 (06406
	Dhusisian	1. Decedent's Name (First, Middle, Last)	2	. Date of Death Month Day	3. Time of Death
-	Physiciar /Medica	LOUISE DOWNES WRIGHT ADAMS			009 0305 AM
1	Examine	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Loca	tion of Death 4c. County	of Death
		Caroline Nursing Home	Denton		aroline
	Funeral Director	5. Social Security Number 2 1 9 − 0 7 − 7 7 2 0 6. Sex 1	ff Under 1 Year ff Under 24 Hrs. 8 Months Days Hours Min. 8	. Date of Birth (Month, Day, Year) Dec. 21,1916	9. Birthplace (State or Foreign Country) Maryland
	pue &	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
	the Meryler 28a-f show		Federalsburg		1 ☐ Yes 2√ No
	ufter death with the Mei r items 23a or 28a-f si ninet must be notified Euneral Director	10e.Street and Number 27366 Iron Gate Road	10f. Zip Code 21632	10g. Cifizen of V	What Country? d States
0000	S	3 ☐ 3 ☐ Widowed 4 ☐ Divorced	/as Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Rid □ Yes 2☑ No Specify:	y Yes or No- can, etc.) 14. Race Blace Specify	e - American Indian, kk, White, etc. :: White
Maryland 21215-0020	led within 72 hours lygiana. Ner than "natural; It, the Madical Ex	15. Decedent's Education (Specify only highest grade completed) (Give kille. D Elementary/Secondary (0-12) College (1-4or 5+)	ent's Usual Occupation ind of work done during most of working O NOT use retired)	16b. Kind of Bu	siness/Industry
21	d with	Elementary/Secondary (0-12) College (1-4or 5+)	omemaker	Ow	n Home
B	be filed tal Hygi d other event, I	17. Father's Name (First, Middle, Last)	18. Mother's Name (F	First, Middle, Maiden Surnam	θ)
/lai	should be nd Mental marked c	Vernon Otto Wright	Lois A	nnie Shufel	t
a	end l		Address (Street and Number or Rural F	Route Number, City or Town,	State, Zip Code)
≥ .	gas 1 and 2 should be filed wil to f Heelih and Mental Hygian If item 27 is marked other thu or other traumetic event, the TO Re Com	Barbara Walters/Daughter 1381	1 Oakland Rd. R:	idgely, MD	21660
ore	of Ho of Hiten fitten	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposementery, crem	ition (Name of atory or other place)	Date 20c. Location -	City or Town, State
Ë	ment ment ment ment ment lury c	4 Donation 5 Other (Specify) Concord	Cemetery 2/2	0/09 Denton,	Maryland
Baltimore,	parmit. Pegas 1 end Depertment of Heelth Important: If Item 27 any injury or other to once.		Name and Address of Facility amptom Funeral Home, 2	16 North Main St ederalsburg, MD	reet,
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac or re	ederalsburg, MD	Approximate
j	Physician (Madian)				Interval Between Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Congestive I Due to (or as a consequence of the coronary Av	neart Failur	e	2 Months
		Due to (or as a consequ	ence of):		11000 410
	Insit			2	MONTHS
90,	ntificate be axecuted ng physician and a st the bunal-transit Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of the condition	ence of): I		1
68760,	g physician as the bun	resulting in death) Last	ence of):		
Вох					
Э.	deat re ett ed fo	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23b. Did tobacco use con	tribute to the cause of death?
P.O.	et the	Diabetes Mellitus		1 □ Yes 2 No	3 ☐ Probably 4 ☐ Unknown
S,	as the digner be d	77200703770111703			
of Vital Records,	The law requiras thet tha death certificate be axeculate has been signed by the ettending physician and page 2 should be datached for use as the bunial-tranCompleted by Physician/Medical Exan			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
- H				1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
/ita	ician: The certificate rector, pag	25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)	
7	Physician: this certific ral director,	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient		5 ☐ Residence 6 ☐ Othe	er (Specify)
ב	After the uners	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	d. Describe how injury occurr	ed
sio	Attending tr deeth. •ctor: After by the fune iffication	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No		
<u>–</u>	tal or At rs aftar c al Direct led in by	4 Homicide determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify)	et, factory, office 281	. Location (Street and Number City or Town, State)	er or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7	29a. Certifier (Check only one) 12 Certifying Phyeician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investant manner stated.	occurred at the time, date and place, and stigation, in my opinion, death occurred	due to the cause(s) and ma at the time, date and place, a	nner as stated. and due to the cause(s)
	within To the comp		29c. License number 3/326	29d. Date signed	(Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, P	rint)		00/
		James Sides MD 920	Market St	Denton	Md 21629
	State	31. Date filed (Month Day Year) 32. Degistrar's Signature	a id I		
P DUIN	Registrar	popular p. p.			

Registrar QHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene |_State m Registrar #19a,perF.Home,2/23/09, BA Certificate of Death WCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 15° 2009 Billie C. Arblaster 12:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catered Living at Ocean Pines Ocean Pines Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. B. Date of Birth (Month, Day, Year, 5/23/1919 Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** 1 1 M 2 □ F Days Hours 89 204-10-4892 Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be 12 differed at 1 ☐ Yes 2 XNo Funeral Director MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 36 Fort Sumter South 21811 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or itel 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No ģ Specify: Specify. 3 Nidowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreman Machine Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Arblaster Katherine Crocker ပ 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Shuvala Judith Ann Chuvala 36 Fort Sumter South, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Castle View Gardens 2/19/2009 New Castle, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** POR PENSIVE /Medical to fur as a consequence of): Examiner AD56125 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown s been si should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 s autopsy perform spital or Attending Physician: Tr nours after death. neral Director: After this certificate y filled in by the funeral director, pa 1 □ Yes 1 ☐ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted 1 Tyes 2 MiNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated Signature and title of certifier 2.16.2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ENWIN CASMNEDAMO 18324 OD OCE AN CCTYBIVD RENIEW, ND 2/8/1 BA 5+1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Viewa

Amended #s 25, 27; nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 02/13/09, Allegany Co. State of Maryland / Department of Health and Mental Hygiene 06408 Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 **Physician** February 8:55P. Dəvid F. Beard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hillhaven Assisted Lvng. Nursing and Rehab Ctr Adelphi Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug 1, 1912 9. Birthplace (State or Foreign OFTO 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 XM 2□ F 572-56-6541 Months 96 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 ehr... any injury or other traumatic event, the Menter's Experiment. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Prince George's Adelphi Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20783 3210 Powder Mill Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No White Specify: Specify: ð 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Researcher SEED 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Stella James M. Beard Leimgruber 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nancy Bell -Daughter 2416 Arrowhead Road Port Republic, Maryland 20676 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Metropolitan Crematory 2/11/2009 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License e GPCHURCH FUNERAL HOME, P.A. 202 Greene Street Cumberland, Maryland 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician FRYCTURE HP RIGHT /Medical Due to (or as a consequence of): Examiner とういとうかいろくん ことしん Sequentially list conditions, 1 ary, leaving to include cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of The law requires that the death certificate be executed as the burial-transit PULTURSICA that initiated events resulting in death) Last Due to (1 as a consequence of): and P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day p Month Year 5 Other (specify) ☐Yes 2☐No be detached the 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an COSTRIBIUM DIFFICH 1 Yes 2 4 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) Yes 2010 ဠ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred /= 2 28b. Time of 27. Manner of Death Certification: Injury 03 5 Pending investigation ASSISTED LIVING December 14 1 Yes 2 No 2008 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 3 2/0 Pour Serial determined 4 Homicide Adi ord Resider ASSUSTER Living ake 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospitel or Attending Physicien: The law requir
 Lat hours after death.
 Funeral Director: After this certificate has been si
elegiy illed in by the funeral director, page 2 should

To the To the To the 20

nos

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas E. Maslen, M.D. 7525 Greenway Center Drive, #316 Greenbelt, Maryland 20770 31. Date filed (Month, Day, Year) FEB 1 3 2009

5

32. Registrar's Signature

29a. Certifier

29b. Signature and title of certif

29c. License number

D55559

29d. Date signed (Month, Day, Year)

FOBRUIR,

10, 2009

09-01194 Darryl Bigger Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2009 06409

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Physicia		Registrar 1. Decedent's Name (First, Mi	ddle,Last)					2	. Date of Death		3. Time of Death
ical Exami		DARRYL	EUGEN	E BIGG	ER				February 9,		2105 hrs
		4a. Facility Name (if not institu			·		Town, or Location of	of Death		4c. County of Dea	
		Eastbound Randolp					r Spring	0411	0. Date of Digital	Montgomery (MM/DD/YYYY) 9. E	
Funeral		5. Social Security Number	6. Sex	_ ' '	rs. last birth	day) If Und Mont				Fore	eign
Director		215-94-567		F 4.	4	Yrs.			Jan.5	,1965 M	aryland
any	- 1	Usual Residence of Decedent 10a. State 10b. Coun		10c.	City, Town o	r Location				· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
* .		MD Moi	ntgome	257	c i 1	TOP Cr	mina				1 Yes 2 X No
ırylanı Sa-f sl	횽	10e. Street and Number	regome.	<u> </u>	211	ver Sr	p Code		100	g. Citizen of What Co	ountry?
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with t		11. Marital Status		Vas Decedent Ever	in U.S.		ent of Hispanic Orig			14. Race - Am	erican Indian, Black,
death or iten	Funeral	1 XNever Married 2	Married A	rmed Forces?	No	if Yes, spec	ify Cuban, Mexican	i, Puerto R	ican, etc.)	White, etc.	
after	by F		Divorced If Yes, or Date	es:			X No specify:		I	Specify: B	lack
hours 'natur		15. Decedent's Education (S Elementary/Secondary (0-		nest grade complete ollege (1-4 or 5+)	d) 16a. L	uring most of w	I Occupation (Give orking life. DO NOT	use retire		166. Kind of busines	s/illdustry
36 nin 72 e. than tulical	Completed	12th	2)	ollege (14 of 5+)		Self-E	mployed			Truck	Driver
215-0036 be filed within 7 ntal Hygiene. rked other than ent, he M dica	Son C	17. Father's Name (First, Mid	dle, Last)				18.Mother	r's Name (I	First, Middle, Ma	aiden Sumame)	
215 be file ntal H rked o	Be (Gasery W:	ims				В	rend	la Bigo	ger	
D 21215-003 should be filed within and Mental Hygiene. 7 is marked other that is a fire event, the Median control of the marked other than a fire event, the Median control of the marked other than a fire event, the Median control of the marked other than a fire event, the Median control of the marked other than a fire event, the Median control of the marked other than a fire event, the Median control of the marked other than a fire event, the Median control of the marked other than a fire event.	2	19a. Informant's Name/Relation								per, City or Town, Sta	1
Z pata Z m		Brenda Bio	ger (I	•			octagon ame of cemetery,		SILVE	er Sprin 20c. Location - City	g,MD 20904
Baltimore, permit. Pages I ar Department of Hee Important: If ite		20a. Method of Disposition 1 Burial 2 XCrema	tion 3 Re	moval from State	cremato	ory or other plac	e)			,	·
timent trant:		4 Dorlation 5 Other	Spegify:		Arden	t Crem			7/09	Hanove	
Baltimore permit. Pages I Department of H Important: If i	1	21. Sometime of Funeral Serv	Cercensee	pwt/s	Er Son						HOME, P.A. e,MD 20850
Physician		23a. Part I. Enter the disease	, or complication	ns that caused the d	leath Do no	t enter the mode	of dying, such as	cardiac or	respiratory arres	st, shock, or heart	Approximate Interval
"Medical		failure. List only one car Immediate Cause (Final dise	use on each line	e. ple Injuries							Between Onset and Death
taminer		or condition resulting in death		(or as a consequer	nce of):			= 1			
	_	Sequentially list conditions,	b								
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60, ate be ex ohysiciar re burial	Medical	UNPENDED		NDED						23d. Date of deliv	100/
876 iificate ng phy is the		IF FEMALE: 23b. Was decedent pregnant		. If yes, outcome of Live birth	pregnancy 2	Fetal deat	h 3 Ectop	ic pregnan	су	Month Month	Day Year
Box 687 Re death certific The attending pred for use as the	sician/	past 12 months? 1 Yes 2 No 9	Linksows 4	Pregnant at time			ecify)				
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tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach	ted								24a. Was a		autopsy findings available
Records, The law require ficate has been si, page 2 should b	ompleted								autops perform	med? death	
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Vital Reconsider: The land in certificate had director, page 2	Be	25. Was case referred to med examiner?	Hospita	1 Inpatient	2 FR/O	utpatient 3	DOA Other			Residence 6 🗸 O	ther: Scene
of Vital ling Physician: After this certi funeral director	: To	1 ✓ Yes 2 No 27. Manner of Death	2	8a. Date of Injury		Time of Injury	28c. Injury at Wor	rk?	28d. Describe h	ow injury occurred	
ion (tending eath.	tion		ending	eb 9, 2009	2055	5 hrs	1 Yes 2 ♥	/ No	oriver auto ti	ixed object colli	sion
Division tal or Attendir rs after death.	ifica		nvestigation 2	8e. Place of Injury	At home, fa	ırm, street, facto	ry, office building, e	etc.	28f. Location (S or Town, St		Rural Route Number, City
Division Hospital or Attent 24 hours after death Fruneral Directors ttely filled in by the	Certification	4 Homicide	letermined ((Specify) Local S					astbound Ra	ndólph Road at O	ctagon Lane, Silver Spri
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial trans		29a. Certifier (Check only 1 Certifyin	g Physician: To	the best of my kno	wledge, dea	ath occurred at t	he time, date and p	lace, and o	due to the cause	e(s) and manner as s and place, and due to	stated.
To the Hos within 24 h To the Fin	ledical		and r	ne basis of examina manner stated.	uon and/or n		9c. License numbe		umo, date e	29d. Date signed	
	Σ	29b. Signature and title of ce	uner			1	O.C.M.E.			February 10, 2	• •
5		min	J, M	atod equal of desti	(Itom 20a)						
		30. Name and address of per Ling Li, MD Assi				n Street, Ba	timore, MD 21	201			
S	tate	31. Date filed (Many Cay Ye		32 Registrar's S							
Reais	trar	1 1	3 2009	Cleneur	1. 1	and arked					

			1 - For State of Maryland / Dep	eartment of Health and ertificate of Death		iene	. 061.10
	Physic /Medi	cal	Decedent's Name (First, Middle, Last) Margaret M. Beary		2. Date of Deat Month Februar	h Day Yea	3. Time of Death
F	Exami uneral rector		4a. Facility Name (If not institution, give street and number) 3510 Forest Edge Drive, #2G 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 577-20-3729 1□ M 2⊠F 85 Yrs.	4b. City, Town, or Location of Dea Silver Spring If Under 1 Year If Under 24 Hr Months Days Hours Mir	ath	4c. County of De	eath ery irthplace (State or Foreign
		tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation	March 2	5, 192β	Maryland 10d. Inside City Limits
ith with the	23a or 28a unt benedii	ral Director	10e. Street and Number 3510 Forest Edge Drive, #2G	ver Spring 10f. Zip Code 20906	10	og. Citizen of What C	1 □ Yes 2X □ No Country?
aryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	ed other than "natural", or items 23a or 28a-f show event, the Medical Evanirar must be rediffed at	ed by Funeral	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (: If Yes, specify Cuban, Mexican, Puei 1 □ Yes 2 ⊠ No Specify:	(Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene.	marked other than "na matic event, the Medic	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of wo DO NOT use retired) maker	orking	6b. Kind of Business Own Hom	s/Industry
/lan	rked o tic eve	To Be	Arthur Joseph Middleton		me (First, Middle, Ma		
Mar)	rauma		19a. Informant's Name/Relationship (Type. Print)	g Address (Street and Number or R	Ethel Bure	City or Town, State.	Zip Code)
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permit. Departm	any Injury o		21. Signature of Figneral Service/Licensee 22.	eaven Cemetery Name and Address of Facility rancis J. Colling OUniversity Blue	2009		ring, Maryla
Exam	dical niner	ner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	er the mode of dying, such as cardiad	c or respiratory arres	t,	Approximate Interval Between Onset and Death
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requires th	hould be de	`∣ה	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.		co use contribute to	the cause of death?
Physician: The law	ector, page 2 s	Deleginos ag	25. Was case referred to medical examiner?	26 Place of Deat	24a. Was an autopsy performed 1 Yes 200	? prior to c	opsy findings available ompletion of cause of
Attending Phys death. ctor: After this	led in by the funeral dir	2	1 Yes 2 No	3 DOA Other: 4 Nursing Ho 28c. Injury at Work? M 1 Yes 2 No	ome 513 Residence 28d. Describe how in		ify)
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To the H within 24 To the Fu	Completely fi	2	(Check only one) 2 Medical Examiner: On the basis of examination and/or investant and manner stated. 9b. Signature and title of countier	stigation, in my opinion, death occurr	red at the time, date a	and place, and due t	o the cause(s)
15		30	D. Name and address of person who completed cause of death (Item 23a) (Type, Prin	D21528		Date signed (Month, February	
	State		Eric D. Anderson, MD 3800 Reservoir	Road, NW, Washi	ngton, DC	20007	
Reg	gistrar		FFB 13 2009 Chara S. Agar				

State of Maryland / Department of Health and Mental Hygienes 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Martin Walter Barylski February 12. 2009 12:25 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 221 Booth Street, #121 Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2 □ F Months Yrs 494-24-3471 Director 81 Nov. 30, 1927 Missouri Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 221 Booth Street, #121 items 23a IISA Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 XYes 2 No Baltimore, Maryland 21215-0036 ò If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: Specify: White ğ 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Electrical Engineering Project Manager other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Barylski Agnes Endraske ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Isabelle H. Barylski/Wife 221 Booth Street, #121, Gaithersburg, MD 20878 of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It any Injury or o 1₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. . 16, 2009 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility ins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Parkinson's vears /Medical Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause for Uncertaing Cause (Disease or injury that initiated events months Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-tra resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician the burial Physician/Medical anding pure IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an nis certificate has director, page 2 performed' 1 ☐ Yes 2 **X** No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2X No Other: 4 Nursing Home 5 NResidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 1 24 hours after death
 e Funeral Director;
 detely filled in by the filled 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 24 hou To the Fune completely fi Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) February 12, 2009 30. Name and address of person who completed use of death (Item 23a) (Type, Print) Ira Berger, MD 1201 Seven Locks Road, #111, Rockville, MD 20854 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 13 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 10:55ам Carl Gwin Baker February 11 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Months Days Hours Min Director 215-38-9949 November 27,1920 Kentucky 88 Usual Residence of Decedent death with the Maryland 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If the 23s or 28s-f show Important: If the 23s or 28s-f show any follury or other traumatic event, It a Medical Examination at the profitted at Director 1 ☐ Yes 2 ☒ No Maryland Montgomery 01nex 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 19408 Charline Manor Road 20832 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify ۾ Specify 3 Widowed 4 Divorced White WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Medical Doctor/Cancer Research Admin NIH - NCI 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Forrest Baker ပ္ Naomi Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Baker - Wife 19408 Charline Manor Road, Olney, Maryland 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Baltimore Crematory of Loudon Park 02/12/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Myelin 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Prostate Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Bladder Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-tran Thrombocytopenia resulting in death) Last Due to (or as a consequence of) Physician/Medical Hematuria use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed I page 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1 □ Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Hospice After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation within 24 hours after deaun.

To the Funeral Director: Af 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) me KOUATCHOU, MI) 30063748 Jecett, February 12, 2009

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Division of Vital

Jocelyne Kouatchou, M.D., 6001 Muncaster Mill Road, Rockville, Maryland 20855

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FEB 13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Day Month Year **Physician** George Carlton 2009 20:50 Brown February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Medical Center Fort Washington Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 □ F **Funeral** Hours Months Days 578-64-4014 60 May 20,1948 Director Washington DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. and the them 27 is marked other than "natural", or items 23a or 28a-f show ant: if item 27 is marked other than "natural", or items 23a or 28a-f show unt; it item 27 is marked other than "and or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 1 ☐ Yes 2 No Director MD Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2905 Crestview Court 20603 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Analysts Federal Govt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Joseph Brown Mildred Jones ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Brown/Wife 2905 Crestview Court, Waldorf, MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ABurial 2 □ Cremation 3 □ Removal from State 2/20/09 MD. Veterans Cem. Cheltenham,MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A M00945 20646 211 St. Mary's Ave. La Plata, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Gastric Cancer Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, Lading Limit and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending IF FEMALE for use a 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à 2 No 3 Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe 1∐ Yes 2 No this certificate Attending Physician: rr death. director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☑ ER/Outpatient 3□ DOA Certification: To After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manper of Death 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director; At completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifie

Deepak

Sachdeva 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 17 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 11711 Livingston Rd. Fort Washington, MD

MD

29c. License numbe

D4674

29d. Date signed (Month, Day, Year)

Februar

2009

		For State	State of Marylai		rtment of H tificate of D			71	009	06414
		Registrar 1. Decedent's Name (First, Middle, Lasi)		incate of L	Jeani ————————————————————————————————————	2. Date of Dea			3. Time of Death
Physicia		Cecile Barbour	,				Month Februar	Day	2009	9:05 a ^M
/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	reoruar		nty of Death	9.03 a
LXumin	CI	Genesis Eldercare			Waldorf			Cł	narles	
Funeral		Social Security Number 6. Se		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	th v. Year)	9. Birthp	lace (State or Foreign
Director		3/9-/4-49/3	^{□ M 2} F 103	Yrs.	Monaro Bayo	Tiodio IVIII.	Dec. 14	1, Year) 1905	5 Mary	land
and	ł	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Loc	cation				11	0d. Inside City Limits
Maryl	to	Maryland Charles		Bryans	Road					1 ☐ Yes 2 ☐ X No
n the r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Coun	try?
th with	alD	3059 Warehouse Lan	ding Road		20616			U.S.	.A.	
rdea	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2X No	J.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. F	Race - Americ	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Inspertment of Health and Mental Hygiene. In Inspertment of Health and Mental Hygiene. In Inspertment: I then Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examination and once.	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	1	□Yes 2□XNo	Specify:	,		ecify: Whi	
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ages ent of it: If If		1 Burial 2 Cremation 3 ☐ 4 Donation 5 ☐ Other (Specify	Removal from State	cemetery, crem	sition (Name of natory or other place	Feb. 19	, 2009		rf, Mar	
mit. F partmo ortan injur		21. Signature of Funeral Service Licent			Memorial . Name and Addres					-7
Per Der any any any		Willahlle	M0066	68 W	Name and Addres illiams F 270 Hawth	uneral Ho orne Rd.	ome, P.A , India	A. n Head	. Md. 2	20640
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Physician		Immediate Cause (Final disease or condition	X+R	Al	MB	RILLA	4770	7	_	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	•					
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ntifica ng ph	Med	IF FEMALE:								
eath certifi attending for use as	ian/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	tal death 3 □	Ectopic pregnancy	/			Date of delive Month	ery Day Year
Attending Physician: The law requires that the death cert redeath. r death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Physician/M	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	fdeath 5□	Other (specify)				MONG	Day Teal
that the dened by the a		Part II. Other significant conditions co	entributing to death but not re	sulting in the ur	nderlying cause give	en in Part 1.	23e. Did t	obacco use c	ontribute to th	ne cause of death?
uires tha n signed ld be det	d by	-AilurE	TO THI	RIVE	5		1 🗆	Yes 2 N	o 3 Prob	ably 4 Unknown
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nysic his ce	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 [☐ ER/Outpatien	t 3 DOA Othe	er: 4 Mursing Ho	ome 5 Resi	dence 6	Other (Specifi	y)
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ttend death. tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be	One Disease of the control of the co			Yes 2 □No				
or A after Direc	ertification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, rarm, stre	eet, ractory, onice		City or To	Street and Nu wn, State)	imber or Hura	l Route Number,
spital lours neral	ပ	29a. Certifier Certifying Phy	ysician. To the best of my kr	nowledge, death	n occurred at the tin	ne, date and place,	and due to the	cause(s) and	d manner as s	tated.
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical Exam	Iner: On the basis of examinand manner stated.	nation and/or in	vestigation, in my o	pinion, death occur	rred at the time,	date and pla	ce, and due to	the cause(s)
To the To the Complex	ž	29b. Signature and title of certifier	1		29c. License	number		29d. Date siç	gned (Month,	Day, Year)
		1 900	7		DI	1443	6	HER	RYAR	4 17 2009
BRIL		30. Name and address of person who o	ompleted cause odeath (Ite	em 23a) (Type, I	Print) PA	11 . 48)	AT I	. 4 . ^	00 41	Day, Year) Y 17 2009 D 20602
として	to	ASHVIN CUM+ 31. Date filed (Month, Day, Year)	32. Negistrar's Sign	nature -	102180	ALME HOP	4 C1 6	VALUE	KIM	J 2602
Sta Registr		FEB 17 20	09 Breus	A. 100	wed					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Feb. G. Burnett 2009 II, 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Peartree House Pasadena Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 12/21/1920 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 ₹ M 2 □ F 498-14-1851 88 Columbia MO Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show event, the Medical Exaciling youst be notified at Director 1 ☐ Yes 2 No Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1516 Briarcliff Road 21012 23a Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 ☐ No þ If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 Divorced White natural Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sales Shoe 7 Is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Granville Burnett Bessy Lee Bruner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Importent: If Item 27 any Injury or other to once. 27 Burnett Spouse 1516 Briarcliff Road Arnold, MD 21012 Norma 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Atlantic Crematory 2/12/09 Glen Burnie,MD 4 ☐ Donation 5 ☐ Other (Specify) 21401 21. Signature of Funeral Service Ligenage 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave Ann, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lic art failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final **Physician** pmen ,ea disease or condition resulting in death) /Medical Die to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physicien: The law requires that the deeth certificate be executed physician and the burial-transi Due to (or as a consequence of) Physician/Medical attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Completed 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No-24a. Was an certificate 2 100 1 □Yes After this certification, funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 100 Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation nours after death.

neral Director: / 2 Accident 1 ☐ Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29b. Signature and title of certifie 29c. License numbe 29d. Date signed Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print),

State Registrar

31. Date filed (Month, Day, Year)

FEB

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

32. Redistrar's Signature

			For State Registrar		State	ot Mai	ryland		irtment of F <i>tificate of</i>				liene _{eg. No} 2 (009	06416	
	Dharaini		1. Decedent's Name (First	Middle, Las	st)							Date of Dear Month	Day	Year	3. Time of Death	
	Physicia /Medic		Upshur		Berk.	1ey						Feb. 13	_		8:50 P M	
	Examin	er	4a. Facility Name (If not in						4b. City, Town, o		of Death			nty of Death		
16			Bradford Oa 5. Social Security Number	aks Nu			(In yrs. las	t hirthday)	Clin		r 24 Hrs.	8 Date of Birth		ice Ge		n
L	Funeral Director		223-05-9807	1	Ճ м 2□ F	9		Yrs.	Months Days	Hours	Min	8. Date of Birth (Month, Day) Aug. 3,	^{Year)} 1914	Rich	place (State or Foreign intry) mond, Va.	_
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	n 282	Director	10e. Street and Number						10f. Zip Code			1	0g. Citizen o	of What Cou	ntry?	_
	th wit		6500 Roberts	Drive	2				2074	-8			USA			
	ems	Funeral	11. Marital Status		12. Was Dec		er in U.S.	13. \	Vas Decedent of F Yes, specify Cub	lispanic C an, Mexica	rigin? (Spe	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White,		
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Evan		1 ☐ Never Married 2[3 🗗 Widowed 4 ☐ Di		1 ∐Yes If Yes, Gi	ive)		□Yes 2t No	Specif			Spe	cify:		
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State of Maryland / Department of Health and Mental Hygiene 2009 0641

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		To the vithing the congression of the congression o	Me	29b. Signature and title of certifier					290		n, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CNV/S Snyder, DME 100 E. CARRIN/ ST. SAL/Sbyry, MD State 31. Date filed (Month, Day, Year) 2000 32 pegistrar's Signature				1 She Is	ME		450	49)		2/16/09	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Isaac Edward Bowen 02 11 2009 10:45AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Envoy of Denton Denton Caroline If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 03/17/1926 Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F 82 Yrs. 216-18-9792 Director MD Usual Residence of Decedent with the Maryland r 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo MD Caroline Henderson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a or 2 miner coust be n 16840 Henderson Rd. death \ 21640 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 \ 1944 to Year or Dates: 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 🗓 No Specify: White r than "naturel", o þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) th and Mentel h Be permit. Peges 1 and 2 should be Depertment of Health and Mentel Importent: If Item 27 is marked, any liqury or other treumatic everse. Warren Vivian Bowen Eva Janice Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3819 E. 9th St., North Beach, MD William T. Heacock/Friend 20714 20b. Place of Disposition (Name of cemetery, crematory or other place) Pk 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial 2/14/2009 ' 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}
Fleegle and Helfenbein Funeral Home
106 W. Sunset Ave., Greensboro, MD 21639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician erebrovascu weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Or Jon, ing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the e O 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed' certificete 1 Yes 2**2** No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₹No 2 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 BNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. f Director: A 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours efter To the Funeref Dire 4 Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month; Day, Year) 0047534 0.9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 920 Market St., Denton, MD 21629 Wafik Zaki MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 17 2009 Registrar

DHMH 17 Rev 1/2001

RS 2

State of Maryland / Department of Health and Mental Hygie () () 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Leona Yerkie Blackson 02 12 / 2009 0650 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Atria Assisted Living Salisbury Wicomico 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/12/1913 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2∰F Months Days Hours 95 Yrs. 214-10-6495 Wisconsin Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral', or items 23a or 28a-f show Examinational be notified at 1 X Yes 2 ☐ No Directo Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 836 Riverside Rd. 21801 United States death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 2 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Newton Jackson other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill iment of Health and Mental H lent: If item 27 is marked ott Be 2 Earnest Amiel Yerkie Bertha Wilimia Boeck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27526 21801 Paul Jones / Nephew Waller Rd. Salisbury, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place)
Springhill
Memory Gardens permit. Pages 1 Department of H Importent: If ite any injury or ot. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 02/16/2009 * 4 ☐ Donation 5 ☐ Other (Specify) Hebron, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 501 Snow Hill Rd. Holloway Funeral Home, PA Salisbury, MD 2180] and 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Failure **Physician** /Medical Due to (or as a consequence of): Examiner ASCUD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of) Examiner RF attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by to be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been si Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has e 2 certificate 1 ☐ Yes 2 😿 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other. 4 Nursing Home 5 Residence 6 Other (Specify) ASST. Livin Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ 1√10 ٩ After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation d in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Al within 24 hours after or To the Funeral Direc 4 | Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Salisbury, 106 Miltord ST, #504B 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Physician
/Medical
Examiner

Funeral Director

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Its Modical Examines must be notified at

Baltimore, Maryland 21215-0036 ၉ 19a. Informant's Name/Relationship (Type. Print) Tina Parsons /sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cape Henlopen Crem. 2/20/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** lum /Medical Due to (or a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exercises) Examine Due to (or a To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filted in by the funeral director, page 2 should be detached for use as the burial-transit ASCVI that initiated events resulting in death) Last Due to (or a Box 68760. Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No 5 Other (specify) P.O. 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 ☐ Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifie 063199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 4 614 EASTERN Shone DR. SAlisbury Md. 406ESH VOHRA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 ORIGINAL

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death John Bilous 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death • 4b. City, Town, or Location of Death WICOMICO Conte TENINSULA COICAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Yea) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1**X** M 2□ F 57 Days 214-60-8144 0H Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10101 Pin Oak Dr. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Owner/Operator Gift Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Iwan Bilous Titiana Unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5818 Morris Rd., Pittsville, MD 21850

Frankford, DE

Burbage Funeral Home 108 William St., Berlin, MD 21811

ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, line.	Approximate Interval Between Onset and Death
s a consequence of);	
s a consequence of):	
),	
s a consequence of):	

23d. Date of delivery Day

> 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24a. Was an

Year

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy perform 2 1 No

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

			For State Registrar	State of	Maryla	nd / Dep	artment of rtificate of	Health ar	nd Mental H		2 11 11 (1 06421
			Decedent's Name (First, Middle	e, Last)					2. Date of E	Reg. No		3. Time of Death
ı	Physici /Medio		RANDOLPH	LEE	BLA	ACK			Month FEBRU	Day	Yea 2009	r
	Examin		4a. Facility Name (If not institutio				4b. City, Town,	or Location of E			County of De	
			FREDERICK MEM				FREDER			F	REDERI	CK
	Funeral Director		5. Social Security Number 239-50-3521	4707 14 0 13 5	7. Age <i>(In yr</i> . 73	s. last birthday) Yrs.	If Under 1 Year Months Days		Min (Month)	Day Voor		irthplace (State or Foreign Country)
			Usual Residence of Decedent		/3	113.			Aug. 3	1,193	5 No	rth Carolina
	how	_	10a. State 10b. County		10c. C	City, Town or Lo	cation					10d. Inside City Limits
	Ba-f s	Director	Maryland Freder	rick	Mi	.ddletov	m					1 □Yes 2 No
	vith th		10e. Street and Number				10f. Zip Code			10g. Citi.	zen of What C	Country?
	sath v	Funeral	6903 Picnic Woo				21769				ed Sta	tes
	ter de	Fun	11. Marital Status 1 □ Never Married 2 ☑ Marr	12. Was Deced Armed Ford 1 □ Yes	es?	J.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin an, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	lo-	14. Race - Am Black, Whi	nerican Indian, ite, etc.
93	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	3		1∐Yes 2⊠No	Specify:			Specify:Wh	ite
21215-0036	72 ho	Completed	15. Deceden (Specify only higher	's Education		16a. Dece	dent's Usual Occu	pation		16b. Kir	nd of Business	s/Industry
121	vithin ine. han "	mpl	Elementary/Secondary (0-12)	College (1-4	lor 5+)	iiie. i	kind of work done DO NOT use retire	during most of d)	working			
	filed within 72 hours after death with the Maryland Hygiene. vither than "natural", or Items 23a or 28a-f show ant, the Modical Examiner mant be notified at		12 17. Father's Name (First, Middle,	(act)		поше	Builder				struct	ion
Maryland	Mental arked o	To Be	Carson R. Black	•					Name (First, Middle		Surname)	
ary	should and Men is marke aumatic	-	19a. Informant's Name/Relations			19b. Mailin	a Address (Street		ence Coor		Town State	Zin Code)
	and 2 ealth a n 27 is		Mary Black / W	ife					, Middlet			
ore	Pages 1 nent of H int: If iten iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Demount from Ct	20b.		sition (Name of natory or other place		Date		cation - City or	
altimore,			4 ☐ Donation 5 ☐ Other (S)	pecify)	ato	. Zion	Lutheran	2/	,			Maryland
Ba	permit. Departr Importa any inji		21. Signature of Funeral Service I	now !		111	00 N. Ma	ple Ave	tauffer E Brunswi	.ck, M	11 Home ID 2171	e, P.A.
			23a. Part 1. Enter the disease, or shock, or heart ailure. List	complications that cau	sed the dea	th. Do not ente	er the mode of dyir	ng, such as car	diac or respiratory	arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			quence of):						Onset and Death
	Examiner		, essening in doubly					-				
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consec	nellih	<u> </u>					yens
	nd	Examine	triat initiated events	. H	perch	ales terale	co.M					Gears
Š	icate be executed physician and the burial-transit	Ĕ	resulting in death) Last	Due to (or	as a consec	quence of):	-					762-
8/60,	ficate be executed I physician and s the burial-transit	dical	ig i	d								
×	certif nding ise as	Me	IF FEMALE:	23c. If yes, outco	me of prean	ancy						
žog .	ding Physician: The law requires that the death certif. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live bir	h 2 Feta	al death 3 🗌	Ectopic pregnanc Other (specify)	у		23	3d. Date of de Month	livery Day Year
5	by the	y y	9 Unknown	9 □ Unknov	'n							
Š.	es tha	b l	Part il. Other significent condition	ns contributing to deat	h but not res	ulting in the un-	derlying cause give	en in Part I.	23e. Did 1	tobacco us	e contribute to	the cause of death?
ecords,	een s nould	g	Hypertension						_ 1□	Yes 2 🗷	No 3□P	robably 4 🗆 Unknown
ec Ec	e 2 sh	Completed							24a. Was		24b. Were au	topsy findings available
VII	r: Th									rmed?	death?	completion of cause of
_	siciar certif	ן מ	25. Was case referred to medical examiner?	Hospital:			Tout-		Death (Check only o			
5	a Phy er this eral d	2	1 Yes 2 No 27. Manner of Death	1 ☐ Inp		ER/Outpatient		4 LI Nursing	g Home 5 Resi			cify)
5	fu tage	፬	1 Natural 5 Pending 2 Accident investiga	(Month,	Day, Year)	Injury	28c. Injun Work	rai ? ′es 2 □No	28d. Describe	now injury (occurred	,
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DIVISION OF VI	oital or Attenurs after deathurs after deathural Director:	Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of building,			et, factory, office		City or for	vn, State)		ural Route Number,
IN IO HOISINIO	ne Hospital or Atten n 24 hours after deat te Funeral Director: bletely filled in by the	suicai Certificat	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could no determin	t he	st of my kno	wiedne death	Occurred at the tim	ne, date and pla	City or for	vn, State)		
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DIVISION OF	To the Hospital or Atten within 24 hours affer deatl To the Funeral Director. completely filled in by the Date of Total Completely filled in by the Date of	Medical	3 Suicide 4 Homicide 6 Could no determin 29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the becaminer: On the basi and manner	st of my kno s of examina stated.	wiedge, death tion and/or inve	occurred at the timestigation, in my operation of the control of t	number	ace, and due to the	cause(s) a date and p	and manner as lace, and due signed (Month	s stated. to the cause(s)

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician February 11:51a [™] Martin Roland Biser 8 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1810 Point of Rocks Road Brunswick Frederick Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 2 M 2 □ F Days **Director** 220-34-1057 85 25,1923 <u>Maryland</u> Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinar must be natified at Director 1 Yes 2 No Maryland Frederick Brunswick Pages 1 and 2 should be filed within 72 hours after death with the nent of Health and Mental Hygiene. ont: If item 27 is marked other than "natural", or items 23a or 28a or 28a. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1810 Point of Rocks Road United States 21716 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Yes. Give Specify Specify: 3 Widowed 4 Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer <u>Farmer</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Erie Calvin Biser ပ္ Lizzie Adlyn Coblentz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Biser/ Wife 1810 Point of Rocks Road, Brunswick, Maryland 21716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Manor Reformed Cemetery 2/12/09 Frederick, Maryland 21. Signature of Juneral Service Licenses 2. Name and Address of Facility tauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carunoma **Physician** disease or condition resulting in death) 5410 /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence. If the death certificate be executed Exami sician and burial-transi Due to (or as a consequence of) P.O. Box 68760 attending physician for use as the buria Physician/Medical nse If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for 1 in the past 12 months? Day Ye ar 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached 9 Unknown 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 1 Tes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 1 ☐Yes 1 ☐Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) After t 27. Manper of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural
Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of pertifie 29c. License number 29d. Date signed (Month, Day, Year) aus D-13971 30. Name and address of person who comp ted cause of death (Item 23a) (Type, Print) Robert L. Kaufmann M 300 West 9th Street, Frederick, Maryland 31. Date filed (Month, Day Year) 32. Registrar's Signature State Clenera Registra

)	Sta		30. Name and address of person of TUAN M. To 31. Date filed (Month, Day, Year)	NA.			rint)					ore, MD, 21287
	vithii Cong	Me	29b. Signature and title of certifier	-7.		-		nse number			te signed (Monti	7, Day, Year)
	ne Hospitt n 24 hours ne Funera oletely fille	Medical C	29a. Certifier 1 Certifying (check only one) 1 Medical I	Physician: To the best of pandmanner sta	examination	lge, death (and/or inve	occurred at the estigation, in my	time, date and p opinion, death	olace, and due occurred at the	to the cause(s) e time, date and) and manner as d place, and du	s stated. e to the cause(s)
DIVISION	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	1 Natural 5 Pending 1 ation of be 290 Bloom of injur	ry - At home,		M 1	☐ Yes 2 ☐ No	28f. Loca	ation (Street an or Town, State)		ural Route Number,	
	ig Physic ter this ce neral dire	ျှ	1 ☐ Yes 2 ☐No 27. Manner of Death 1 Natural 5 ☐ Pending	Hospital: 1 Inpaties 28a. Date of Injur (Month, Day	y 281	Outpatient b. Time of Injury	28c. Inj			Residence cribe how injur	6 Other (Spec	city)
	siclan; The lav certificate has irector, page 2	Be	25. Was case referred to medical examiner?	Hospital				Ale e e	Death (Check	only one)	-	2 No
Hec	20 2	Completed			•				-	. Was an autopsy performed?	prior to death?	ntopsy findings available completion of cause of
ras, r	requires that the een signed by th hould be detach	þ	Part II. Other significant conditio	ns contributing to death be	ut not resultin	ng in the ur	derlying cause	given in Part I.	23e			o the cause of death?
0 0	death cer e attendin ed for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	ath 3 ☐ 1 5 ☐	Ectopic pregna Other (specify)				23d. Date of de Month	Day Year
	tificate be executed g physician and as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a d								
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Baltill	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L When Hand 23a. Part 1. Enter the disease, or	icensee	sper	22.	ris & Co	dress of Facility Maryla	Tarring	97 ^C 3399	t Chest Funera	l Home, P.A. Approximate
Baltimore,	Pages 1 and iment of Health tant: If item 27 lury or other tr.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S)		20b. Place ceme	e of Dispos etery, crem	ition (Name of atory or other p	lace)	Date /24/2009	20c. Lo	ocation - City or	Town, State
Maryland	12 shorth and N is ma 7 is material traumaterial		19a. Informant's Name/Relationsh John Beckman (et and Number Drive,	or Rural Route	Number, City o	or Town, State, 2	
land		To Be	17. Father's Name (First, Middle, L John H. Nolte	ast)					s Name <i>(First, I</i> prence (,	
2121	within	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	+)		o NOT use reti	vice				overnment
5-0036	72 hours natural", iical Exa	eted by	3 Widowed 4 Divorced 15. Deceden (Specify only highes	Year or Dates:	1	6a. Decede	ent's Usual Occ		of working	16b. K	Specify: W (ind of Business	hite /Industry
98	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	y Funeral	700 West BelAi 11. Marital Status 1 Never Married 2 Marri	12. Was Decedent I Armed Forces?	Ever in U.S.	13. W		21001 f Hispanic Origin ban, Mexican, F Specify:	n? (Specify Yes Puerto Rican, et		14. Race - Ame Black, Whit	
	with the a or 28a be notifi	Director	10e. Street and Number				10f. Zip-Code			10g. Cit	izen of What Co	puntry?
	Maryland -f show ed at	tor	10a. State 10b. County Maryland Harf	ord	10c. City, To	own or Loc						10d. Inside City Limits 1 Yes 2 No
	Funeral Director		215–30–6904 Usual Residence of Decedent	6. Sex 7. Ag	e (In yrs. last 75	Yrs.	If Under 1 Year Months Day		Min. 8. Date	of Birth hth, Day, Year) /30/193	3 Mar	thplace (State or Foreign unity) yland
	Examir	ier	The Johns Hopkins 5. Social Security Number	Hospital			Baltimo	e City				
	Physici /Medic	al	Florence 4a. Facility Name (If not institution	Marle and number)		Be	LCK MC	or Location of I		ruary 2	Year 23, 2050 County of Dea	9:064 M
			For State Registrar 1. Decedent's Name (First, Middle		arylario ,		ificate of			Reg. No	0000	05423
				State of Ma	arvland	/ Dena		Health ar		l Hygiene	3	

Eli	zabeth	14	Bailey SSIN Please	Type or F		Black In	delible li	nk. Er	nsure A	II Copies	s Are	Legible.	
2/	21/09 (9 11	State Registrar	State of	Marylar		artment d rtificate d			Mental Hy	giene,	2	06424
	Physici	an	Decedent's Name (First, Middle, L.	*	1 4-1-	T) T)			-	2. Date of D Month			3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, g		abeth	R. B	4b. City, Tow	n orloan	tion of Dooth	Februa	* 4	1, 2009 County of Death	6:00 P M
	Examir	ner	Laurelwood C		iber)		1	ton	uon oi Death		40.	Cecil	
	Funeral		· ·	Sex 1 □ M 2 ☑ F	7. Age (In yrs.		If Under 1 You Months Da		nder 24 Hrs. urs Min.	8. Date of B (Month, D March	irth Day, Year)	Cou	
	Director		179-24-2217 Usual Residence of Decedent			76 Yrs.				March	5, 1	.932	MD
	show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					1	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	the Ma	Director	PA Ches 10e. Street and Number	ter	0	xford	10f. Zip Co	de			10a Citi	zen of What Cou	
	death with the Maryland sms 23a or 28a-f show gringt be notified at	al Di	135 Barnsley	Road				363				JSA	,
	items	Funeral	11. Marital Status	12. Was Dece	ces?	l.S. 13.	Was Decedent If Yes, specify	of Hispani Cuban, Me	ic Origin? (Spexican, Puerto	pecify Yes or N Rican, etc.)	0-	14. Race - Ameri Black, White,	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Expratric must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes If Yes, Giv Year or Da	'e		1 □Yes 2 📉		ecify:			Specify: W	nite
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and	be file ntal Hy sd oth event	Be	17. Father's Name (First, Middle, Las	-				18. N		e (First, Middle	,		
ıry	should nd Me marke	ျှ	Stanley Rus 19a. Informant's Name/Relationship			19b. Mailir	na Address /St	reet and N		ie Rus		r Town, State, Zij	n Code)
, Ma	and 2 saith ar		Michael D. M		n	1	-				-	PA 19	,
ore	ges 1 it of He If Item or oth		20a. Method of Disposition 1 ☐ Burial 2 【XI Cremation 3	☐Removal from S		Place of Dispo cemetery, crei	osition (Name o	f place)		Date	20c. Lo	cation - City or To	own, State
Ħ.	artmer ortant: Injury		4 ☐ Donation 5 ☐ Other (Spec	cify)			Cremat 2. Name and A			23-200		Leola,	
Ba	Depar Impor any Ir		Inc. 86 Pine Street,										neral Home, PA 19363
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a C	260	STAG	E Co	PD					Onset and Death
	Examiner			Due to (or as a consec	quence of):							
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Either underlying Cause (Disease or injury	Due to (or as a consec	quence of):							
Ć.	executed in and ial-transit	Examiner	that initiated events resulting in death) Last	c Due to (c	or as a consec	quence of):							
Box 68760	ate be hysicia he bur	lical		d									
% 68	certific ding p	/Med	IF FEMALE:	23c. If yes, outo	come of prean	ancy			- 11				
P.O. Bo	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 Live b	oirth 2 ☐ Feta nant at time of	al death 3[☐ Ectopic pregi ☐ Other <i>(specit</i>					23d. Date of deliv Month	ery Day Year
σ.	s that the ned by detac	by Ph	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	nderlying cause	e given in F	Part I.	23e. Did	tobacco u	se contribute to t	he cause of death?
ords	equires en sig outd be									15	Yes 2[□ No 3 □ Prol	babły 4 ☐ Unknown
3ec	hasbe e 2 sh	Completed								24a. Was	opsy	prior to co	ppsy findings available ompletion of cause of
lal	n: The fficate or, pag		25. Was case referred to medical							1 □ Yes	1	death? 1 ☐ Yes	2EINO
Ž	ystcia iis cert directe	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 □ II	npatient 2] ER/Outpatie	nt 3 □ DOA	045		th <i>(Check only</i> ome 5 □ Res		6 ☐ Other (Specia	fv)
Division of Vital Records,	Ing Ph	on:T	27. Manner of Death 1 Natural 5 Pending	28a. Date o	of Injury h, Day, Year)	28b. Time o		Injury at Work?		28d. Describe			
isio	Attend death ctor: / y the f	ficati	2 Accident investigati 3 Suicide 6 Could n	ho I	of Injury - At h	ome, farm, str		1 ☐ Yes	2 No	28f. Location	(Street an	d Number or Run	al Route Number
ο̈́ς	tal or / rs after al Dire ed in b	Certification:	4 ☐ Homicide determine	buildir	ng, etc. <i>(Speci</i>	ify)	eet, factory, off			City or To	wn, State)	arriodio rumor,
	e Hospi 124 hour e Funer letely fill	Medical	29a. Certifier 1 ☐ Certifying I (Check only one) 1 ☐ Medical Ex.	Physician: To the aminer: On the band mann	asis of examin	owledge, deat ation and/or ir	h occurred at to	he time, da my opinior	ate and place n, death occu	, and due to th rred at the time	e cause(s) e, date and	and manner as s I place, and due t	stated. o the cause(s)
_	To th withir To th comp	Me	29b. Signature and title of certifier					cense num				te signed (Month,	Day, Year)
			17/160					5407	15		23	FEB 09	
7			30. Name and address of person wh	o completed cause	e of death (Ite	m 23a) (Туре,	Print)	10	5 1	Prisie	_ ()F	= 1971	3
	Sta		31. Date filed (Month, Day, Year)	32. 86	egistrar's Signa	ature	001		- 1				
DU	Registi MH 17 Rev 1/2		NAR 022	009 2	un ,	1. 190	ald						
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State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** P^{M} June A. Cross 15 February 2009 5:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WMHS-Frostburg Nursing & Rehab Center Frostburg Alleganv If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 220-10-9148 Director 91 JUNE 9,1917 WEST VIRGINIA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director PA **BEDFORD** HYNDMAN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 341 CHURCH STREET 15545 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Specify: 3 Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 11 HOME f Health and Mental Hygie Item 27 is marked other t other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES ROSS **EVANS** NORA MINERVA SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NORMA J. SHAFF ER / DAUGHTER P.O. BOX 124, HYNDMAN, PA 15545-0124 Department of Health Important: If item 27 any Injury or other tronce. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HYNDMAN CEMETERY 02/19/2009 HYNDMAN, PA 21. Signature of Funeral Pervice Vice see 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Candio vasular Atherosclerotic disease or conditi-resulting in death) 6ments /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the. IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 2 No 1∐ Yes 2 **X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident Injury 1 Yes 2 No after death Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 24 hor To the Fune (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) wonsodshi 00055325 Feb 16, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALSHER Cumberland MD 21502 ness 925 BISHOF WONSOCK SHIN HI) State

Registrar

			1- State Registrar Amended #31 per	State of Maryland		artment of H			ne No.2009	06426
	Physic /Medi		1. Decedent's Name (First, Middle, Last)	FGIID	Co	rouz		2. Date of Death Month Coruary	Day 2009	3. Time of Death
	Exami		4a. Facility Name (If not institution, give str The Johns Hopkins Hos 5. Social Security Number 6. Sex	,	of high days	46. City, Town, or Baltimore If Under 1 Year	Location of Death	8. Date of Birth	4c. County of Death None	1.0
(Sin.	Funeral Director		576-65-9370 Usual Residence of Decedent	12□F 15	Yrs.	Months Days	Hours Min.	(Month, Day, Yea	1993 Haw	place (State or Foreign try) aii
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. They matural", or items 23a or 28a-f show out, the Medical Examiner must be notified at	Director	Maryland Frede:		Town or Lo	cation cederick 10f. Zip-Code		140-	Citizen of What Cour	10d. Inside City Limits 1 Yes 2 No
	death with	Funeral Di	6223 East Huff Bl	. Was Decedent Ever in U.S.	13. \	2170	02 spanic Origin? (Spen, Mexican, Puerto F	U	nited Sta	tes
9000	hours after ural", or ite I Examiner	ğ	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:		Yes 2. X No	Specify:			Asian
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yland	iges 1 and 2 should be filed within 72 hours after death with the Mar It of Health and Mental Hygierian and the thems 23a or 28a-f s or other traumatic event, the <u>Medical Examiner must be notified</u>	To Be C	17. Father's Name (First, Middle, Last) Jude Corpuz					ina Ijan	den Surname)	
e, Mar	1 and 2 sho Health and Sm 27 is mo ther trauma		19a. Informant's Name/Relationship (Type Jude Corpuz / Fathe 20a. Method of Disposition	r	6223	East Huff	Blvd., 1	rederick	y or Town, State, Zip MD 21702	2
_ ⊒	permit. Pages Department of i Important; If its any injury or o		1 ☐ Burial 2 ☐ Tremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		ffer	sition (Name of natory or other place Crematory . Name and Addres	2/17/ s of Facility	2009 F	rederick, rederick	Maryland Home
	hysician		23a. Fart 1 Enter the disease for complica shock, or heart failure. List only one of immediate Cause (Final disease or condition	aid for a death. The sause on each line. Respiratory		er the mode of dying	ssumtown g, such as cardiac o	Pike, Fre	ederick, M	D 21702 Approximate Interval Between Onset and Death
	Centificate be executed ding physician and rise as the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of): HE fra nce of):	5955	lyun's ly	nphoma		== = 75/7
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ecords, P.	v requires triat the dearn been signed by the atter should be detached for	by	Part II. Other significant conditions contri	outing to death but not result	nderlying cause give	lying cause given in Part I. 23e. Did toba			pacco use contribute to the cause of death? s 2 XNo 3 □ Probably 4 □ Unknown	
Hec	ate has	Completed						24a. Was an autopsy performed?	prior to con death?	osy findings available mpletion of cause of 2 No
VITAI	h. After this certificate funeral director, pa	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	pital: 1 Npatient 2 = EF	(0.4	Other	26. Place of Death (
ם ו	r this eral d	은	27. Manner of Death	28a. Date of Injury 2	Outpatient b. Time of	3 DOA	4 LI Nursing Home	Bd. Describe how in	6 Other (Specify)
UNISION	the the	Certification:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury of Injury Work? 1 Yes 2 No 28d. Describe how injury of Injury at Work? 1 Yes 2 No 28d. Describe how injury of Injury at Work? 1 Yes 2 No 28d. Describe how injury of Injury at Work? 1 Yes 2 No 28d. Describe how injury of Injury at Work? 1 Yes 2 No 28d. Describe how injury of Injury at Work? 1 Yes 2 No Year Yes Ye							Route Number,
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į	within To the comple	Σ	29b. Signature and title of certifier Maura (- (Tanin, M	LD		number 1 7 357 T2		ate signed (Month, E XUAYY (2)ay, Year) , 2009
	h)		30. Name and address of person who com MARIA I. CANG 31. Date filed (Month, Day, Year)	Oleted cause of death (Item 2 O , M-D 32 Registrar's Signature		Print)	600 N	orth Wolfe	St, Baltimore	e, MD, 21287
	Sta Registr		ST. Date filed (Month, Day, Tear)	or. negistral s signature	311	FE	B 1 7 2009	Buccas	, A. So	ake

			State of Maryland / State of Maryland / State of Maryland / State of Maryland /	Depa		lealth and M	lental Hy	giene 0 0	9 06427
	Physici		1. Decedent's Name (First, Middle, Last) Wade Cordell Clark			- Journ	2. Date of De Month Februa	ath Day Ye	
1	/Medio Examir		4a. Facility Name (If not institution, give street and number) Citizens Nursing Home			r Location of Death	100100	4c. County of E	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last</i> in 1	<i>birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March 3		Birthplace (State or Foreig Country)
	e Maryland Ba-f show	ctor	10a. State 10b. County 10c. City, To Maryland Frederick Fre	own or Loc ederi					10d. Inside City Limits
	ath with th	Funeral Director	10e. Street and Number 1900 Rosemont Avenue		10f. Zip Code 21702			10g. Citizen of What	Country?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examing must be notified at once.	by	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 □ Yes 2X No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - A Black, W Specify:	American Indian, /hite, etc. white
Maryland 21215-0036	within 72 ho piene. r than "natu the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L	dent's Usual Occup kind of work done DO NOT use retired al Helpe	during most of worki	ing	16b. Kind of Busine	Bussard
land 2	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Pa	To Be C	17. Father's Name (First, Middle, Last) Myrvin Cochran Clark	CHEL	ar_nerpe	18. Mother's Name	(First, Middle,	Maiden Surname)	Dussaid
, Mary	1 and 2 shor Health and I tem 27 is ma other trauma	•	Paul Clark - Brother					er, City or Town, Sta	, , ,
Baltimore,	permit. Pages 1 Department of H Important: If iter any injury or oth		4 Donation 5 Other (Specify)	fer	sition (Name of natory or other place Crematory	Feb 1	6,2009	20c. Location - City Frederick	orTown, State
Bal	permi Depar Impor any ir		21. Signature of Funeral Service Licensee	16	2. Name and Addre	ımtown Pik	ce, Fred	Funeral Ho derick, Ma	ryland 2170
- And	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)	one	er the mode of dyir	ng, such as cardiac o	or respiratory a	rrest,	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence consequence) c. Due to (or as a consequence death)						
O. Box 6	at the death certific by the attending p tached for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dec 4 □ Pregnant at time of death 9 □ Unknown	ath 3 □	Ectopic pregnand Other (specify)	у		23d. Date of Month	delivery Day Year
Records, P.	w requires that s been signed by should be deta		Part II. Other significant conditions contributing to death but not resulting Cong. Kent Portune	in the un	nderlying cause giv	en in Part I.	23e. Did t	11	e to the cause of death? Probably 4 Unknown
Vital Rec	sician: The law s certificate has b irector, page 2 sh	Be Completed by	25. Was case referred to medical			26. Place of Death	1 □ Yes	osy prior deat	
Division of V	ig Phy ter this neral d	Certification: To B	27. Manner of Death Natural 5 Pending 2 Accident 3 Suicide 6 Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Date of Injury 28b. Date of Injury 28b. Date of Injury 28b. Place of Injury - At home,	o. Time of Injury	M 1 🗆	er: 4 Nursing Ho ry at k? Yes 2 □ No	me 5 Residence R	dence 6 Other (and the standard of the standar	Specify) r Rural Route Number,
Ö	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur		29a. Certifier 1 Certifying Physician: To the best of my knowled	dge, death	n occurred at the ti	me, date and place	and due to the	vn, State)	er as stated
	To the Ho within 24 To the Fu complete	Medical	(Check only one) Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier	and/or inv	vestigation, in my o			date and place, and 29d. Date signed (M	
	(2)		30. Name and address of person who completed cause of death (Item 23a	a) (Type, I	Print)	-/397/		2/10/	09
	Sta		Robert L. Kaufman M.D. 300 V		h Street	, Frederi	ck, Mar	yland 21	702
DH	Registr MH 17 Rev 1/2		The second secon	7	FL	B 1 7 2009	Bens	was B.	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 11, 2009 Idella Moore Chappell 10:58AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Egle Nursing and Rehab Center Lonaconing Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country)
 Maryland 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 DS 217-05-0846 December 01, 1914 Director Usual Residence of Decedent 10h. County 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Experies must be rollined at Director 1 XYes 2 □ No Maryland Allegany Lonaconing 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 57 Jackson Street 21539 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. and 2 should be filed within 72 hours after of leath and Mental Hygiene. n 27 is marked other than "natural", or Itel 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 þ 1 ☐Yes 2 No Specify Specify 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ebenezer Moore Maryanne Jones ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: if item 27, any injury or other tra Anne Perry Winner - Daughter 61 East Main Street, Lonaconing, Maryland, 21539 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date February 14 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State **Cumberland Crematory** Cumberland, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neu maria Odays disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed for use as the burial-trans and Due to (or as a consequence of): Box 68760. physiclan Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 1 ∐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ğ Completed 1 🗆 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 \(\square\) No certificate l Con 50stive Division of Vital 1 □Yes 2 No 1 □ Yes funeral director, 25. Was case referred to dical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 NO Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending investigation in 24 hours after the Euneral Director: After the function by the function of 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar eulin,

32. Registrar's Signature

31. Date filed (Month, Day, Year)

December December				For State Registrar	State of Ma	aryland		artment o	f Health	and M		giene		06429
WYCLIFFE T. CASEY SR. PERMANY T. 2006 T. TOTAL CONTROL OF THE CASE PINE PINE PINE CASE PINE PINE PINE CASE PINE PINE PINE PINE PINE PINE PINE PIN					e, Last)			incate c	Dealli				.003	
Securities FUTURE CARE PINSVIEW MYRSING HOME FUTURE CARE PINSVIEW MYRSING FUTURE CARE PINSVIE				WYCLIFFE	т.		CAS	SEY	SR.	. :			2009	
Second Second Foundary Text Tex	44.				-			4b. City, Town	n, or Location					
The control of the co	-											1	NCE GEO	RGES
10. Sides 180. County 100. Chip 180. County 100. Chip 180. Chip 18				235-52-0327	3777					Min.	8. Date of Birt 07-09-1	h y Year) 932	l Cou	ntry)
WILLIAM CASEY Tight informants Name-Flainborning (Figs. Print)		and				10c. City, T	own or Lo	cation						10d. Inside City Limits
WILLIAM CASEY Tight informants Name-Flainborning (Figs. Print)		Mary F-f sh	tor	DC			WA	ASHINGTO)N					
WILLIAM CASEY Tight informants Name-Flainborning (Figs. Print)		or 28%)irec	10e. Street and Number								10g. Citize	en of What Cou	ntry?
WILLIAM CASEY Tight informants Name-Flainborning (Figs. Print)		ath wi	<u>ra</u>	149 TODD PLACE	N.E.				20002			1	U.S.A.	
WILLIAM CASEY Tight informants Name-Flainborning (Figs. Print)		er deg	une		Armed Forces?		13.	Was Decedent of Yes, specify C	of Hispanic Or Juban, Mexical	igin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)	14	4. Race - Ameri Black, White,	can Indian, etc.
WILLIAM CASEY Tight informants Name-Flainborning (Figs. Print)	36	irs aft	ģ		If Yes, Give	NO	.	l∐Yes 2⊠ti	No Specify:			5	Specify: B	LACK
WILLIAM CASEY Tight informants Name-Flainborning (Figs. Print)	Ö	2 hou	ted	15. Decedent	's Education	1						16b. Kind	d of Business/In	dustry
WILLIAM CASEY Tight informants Name-Flainborning (Figs. Print)	2	tthin 7 be. han "r	nple	Elementary/Secondary (0-12)	 	+)	(Give life. L	kind of work do DO NOT use rei	ne during mos ired)	t of workin	ig			
WILLIAM CASEY Tight informants Name-Flainborning (Figs. Print)	2	led wi lygier her th	င်				TRUCK	DRIVE						BUCK
CARLEAN V. CASEY/DAUGHTER SO02 57th AVENUE #41 BLADENSBURG, MARYLAND 20710 Date of Deposition of Programs of Controlling	ylanc	eve d al			,								urname)	
De Brit Service Service Constitution Control of Service Constitution Control of Service Constitution Control of Service Constitution Control of Service Constitution Control of Service Constitution Control of Service Constitution Control of Service Constitution Control of Service Constitution Control of Service Control of Ser	, Mar	nd 2 salth ar				5	19b. Mailin 002 5	g Address (Stre 57th AVI	et and Numb ENUE #A	er or Rural 1 BL	Route Numbe	r, City or T	Town, State, Zip MARYLANI	Code) D 20710
Physician Medical Examiner Physician Medical Examiner Substitute ore	es 1 a of He fitem r othe			2 D 2	20b. Place ceme	e of Dispos	sition (Name of	olace)	Da	ate	20c. Loca	ation - City or To	own, State	
Physician Medical Examiner Physician Medical Examiner Substitute Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (S _k	Becify)				/	2-20-	-2009	ARLIN	NGTON, V	VIRGINIA	
Physician Medical Examiner Physician Medical Examiner Substitute ga	ermit. Derari Inport Ing Inj		21. Signature Funeral Service I	icens	60	/ 22	. Name and Ad	dress of Facilit	JOHN	V T. RH	INES	FUNERAL	HOME LLC	
Physician Medical Examiner Ph		10000	_	flecers	sur	W	130	05 12th	STREE	T N.F	. WASH	INGTO		20017
Securitally list conditions Secu				snock, or neart failure. List	complications that caused only one cause on each lin	the death. Die.	o n ot ente	er the mode of	dying, such as	cardiac or	r respiratory ar	rest,	- 1	Approximate Interval Between Onset and Death
Securitially list conditions Cause Disease or Injury Part Disease				ase or condition	The second secon									
The part of the					THE PROPERTY OF A STATE OF	and accept	SERVICE VOID	C.F.						
The part of the part is maintained events and the part is prepared to the part is maintained events and the part is maintained events. The part is prepared to the part is maintained events and the part is maintained events.		n +	ner	Sequentially list conditions,				SE						
State Continue C		ecuter ind transi	ami	that initiated events										
FEMALE: 23d. Date of delivery 23d. Date of deliv	60,	be ex ician a burial-	<u></u>	resulting in deatily cast	Due to (or as a	a consequent	ce of):							
Same and the past I amonths? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year	287	physicate sthe l	dic		d									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably XE Unknown	ŏ	nding use a	Ž									23	d Date of dollar	200
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably XE Unknown	_•	death e atte	icia	in the past 12 months?	4 ☐ Pregnant at							20		-
25. Was case referred to medical examiner? Types 25 No Page 25 No	л Э	at the by the	hys											
25. Was case referred to medical examiner? Types 25 No Page 25 No	rds,	quires the signed and signed and the de	ģ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
The state of the s	ပ္တ	s bee	olete								24a. Was a	n	24b. Were auto	nsy findings available
The state of the s	ř	The la	E						-		perfor	med?	prior to col death?	mpletion of cause of
The state of the s	Ia	sian: ertifica ctor, p	a						26. Place	of Death			1 Li Yes	2 LIN6
Solution of the part of the pa		hysic this or al dire	၉	1 ☐ Yes 2x ☐No	1 ∐ Inpatiei		Outpatient	3 □ DOA C	Other: 415 Nu	rsing Hom	e 5 ☐ Resid	ence 6	Other (Specif	y)
Solution of the part of the pa	_	Ilng P	<u>ö</u>	1XXIatural 5 ☐ Pending	(Month, Day	y (Year) 28t	o. Time of Injury	V\	ork?		3d. Describe h	ow injury o	occurred	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier (29b. Signature and daddress of person who completed cause of death (Item 23a) (Type, Print) BAHRAM PISHDAD, M.D. 1328 SOUTHERN AVENUE S.E. WASHINGTON, DC 20032	<u>s</u>	death death ctor: y the	icat 	3 Suicide 6 Could n	ot be	ry - At homo	form atro				Of 1			
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier (29b. Signature and daddress of person who completed cause of death (Item 23a) (Type, Print) BAHRAM PISHDAD, M.D. 1328 SOUTHERN AVENUE S.E. WASHINGTON, DC 20032	2	after after Direction by	er	4 ☐ Homicide determin	building, etc.	. (Specify)	iaiii, sire	et, lactory, offic	е	28	City or Town	reet and r n, State)	Number or Rura	I Route Number,
D51520 FEBRUARY 6, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAHRAM PISHDAD, M.D. 1328 SOUTHERN AVENUE S.E. WASHINGTON, DC 20032		spita hours ineral y fille		29a. Certifier 1 Certifying	J Physician: To the best o	of my knowled	dge, death	occurred at the	e time, date an	id place, ai	nd due to the o	ause(s) a	nd manner as s	tated.
D51520 FEBRUARY 6, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAHRAM PISHDAD, M.D. 1328 SOUTHERN AVENUE S.E. WASHINGTON, DC 20032		the Ho lin 24 the Fu	edic	(Check only 2 Medical E	xaminer: On the basis of	examination	and/or inv	estigation, in m	y opinion, dea	th occurre	d at the time, c	ate and pl	lace, and due to	the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAHRAM PISHDAD, M.D. 1328 SOUTHERN AVENUE S.E. WASHINGTON, DC 20032		5 5 6 7	Σ	29b. Signature and title of certifier				29c. Lice	nse number		2	9d. Date s	signed (Month, i	Day, Year)
BAHRAM PISHDAD, M.D. 1328 SOUTHERN AVENUE S.E. WASHINGTON, DC 20032				P // Umg					D51520			FEBI	RUARY 6	, 2009
State Registrar FEB 1 8 2009 32. Registrar's Signature 34. Address A. Addre	2	2		BAHRAM PISHDAD,	M.D. 1328 S	OUTHER	N AVI		E. WASH	IINGT	ON, DC	20032	2	
			~	FEB 1 8 2009	Server 32. Registra	r's Signature	w							

			FOR	partment of Health and M	lental Hygiene	2009 06430
			1 - State Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. No.	3. Time of Death
B	Physicia	an	Norman Walter Calloway		Month Day 02 12	y Year
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
	LAdiiiii	CI	Envoy of Denton	Denton	C	Caroline
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
b.	Director		218-16-6641 1 → 2 F 85 Yrs.		12/06/1923	B MD
	land tt		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Mary -f sh fied a	ţō	MD Caroline Ridgely			1 □Yes 2ÅNo
	th the or 282 s noti	Director	10e. Street and Number	10f. Zip Code	10g. Cit	tizen of What Country?
	23a ust b		23292 Sparks Rd.	21660		JSA
	er deg items ner m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ★ Married 1. Was Decedent Ever in U.S. 1. □ Yes 2★ No	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecity Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc.
36	within 72 hours after death with the Maryland ene. than "hatural", or items 23a or 28a-f show the Medical Examiner must be notified at	by F	1 Never married 2 Married 1	1 ☐ Yes 2 No Specify:		Specify: White
9	2 hou latura ical E	ted		edent's Usual Occupation ve kind of work done during most of work		Kind of Business/Industry
218	thin 7 le. lan "n	Completed	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired)	ii ig	
121	led wi lygier her th nt, the		11 17. Father's Name (First, Middle, Last)	Farmer 18 Mother's Name	e (First, Middle, Maiden	Self
Maryland 21215-0036	should be filed vand Mental Hygies marked other is marked other inmatic event, the	Be		Mildred		r Gurname)
Ž	should nd Me mark matic	욘	Clifford Calloway, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Ma	iling Address (Street and Number or Rui		or Town, State, Zip Code)
Za	nd 2 saith ar 27 is r trau			Academy Ave., Gre	ensboro. MD	21639
re,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 20b. Place of Dis			ocation - City or Town, State
Ē	Page nent c		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Greenmo	unt Cemetery 2/17	/2009 Hil	lsboro, MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licensee	22 Name and Address of Facility Ife:		
	g 0 = # 9		Mesh (Muye	106 W. Sunset Ave		oro, MD 21639 Approximate
		. 0	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final		or respiratory arrest,	Interval Between Onset and Death
E	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	3 DISTIBLE		
	Examiner		Due to (of as a consequence of).			
	a n	Je.	Sequentially list conditions, if any, leading to infinediate cause. Enter I Inderlying.			
	ecutec ind transi	Examine	l'adiy, leading lu infiniedate cause. Enter fuderlying Cause (Disease or injury that initiated events resulting in death) Last			
8760,	ate be executed thysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):			
687	The law requires that the death certificate be executed to has been signed by the attending physician and toge 2 should be detached for use as the burial-transit	dical	d			
Box (leath certific attending p I for use as 1	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy	- De		23d. Date of delivery
	death e atte d for	icia	in the past 12 months? 1 Ves. 2 No. 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
P.0	at the de by the	hys	9 Unknown			
Ś	res that Igned to be deta	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death? 2 No 3 Probably 4 Nonknown
or Vital Record	w requir been sl should l	Completed	THE COUNTY POTE POLITICALIA			
Rec	ne faw has b ge 2 s	mple	HYPER CHOLESTEROLEMIA		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
tal			25. Was case referred to medical	26 Place of Dea	1 Yes 2 No	lo 1 Yes 2 No
>		o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	Othor	ome 5 Residence	6 □Other (Specify)
0	ding Phys I. After this funeral di	T :u	27. Mannef of ath 1 Natural 5 □ Pending (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at	28d. Describe how inju	
Sio	Attending r death. ector: After by the funer	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division	or Att fter de Sirect in by 1	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)
	he Hospital or Attendi n 24 hours after death. he Funeral Director: A pletely filled in by the fu		29a. Certifier 12 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place	and due to the cause(s	s) and manner as stated.
	To the Hos within 24 ho To the Fun completely	edical	(Check only one) Medical Examiner: On the basis of examination and/or and manner stated.	r investigation, in my opinion, death occu	rred at the time, date ar	nd place, and due to the cause(s)
	To the within 2. To the I complet	<u>R</u>	29b. Signature and life of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
			* (THE INLO.	1063063	FER	BRUARY 12 2009
			30. Name and address of person who completed cause of death (Item 23a) (Typ		TANK AAD	01/00
			STEPHEN RUALO, M.D. 609 VA) 31. Date filed (Month, Day, Year) 32 Registrar's Signatyre	FFINI LANE DEN	TON, MD a	X/Qd]
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 1 7 2009 32 Registrar's Signature	anker		

1 - For State Registrar

	Physicia		1. Decedent's Name (First, Middle,	Goldie Marie	e Cissel			Month Februar	Day	2009	0700 A ^M
,	/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town, o	r Location of De			nty of Death	
			171 Middlecrof			Elkton	I If Under 24 F	Irs. 8. Date of Birth		cil Rietho	ace (State or Foreign
	Funeral Director		5. Social Security Number 212–28–4465	6. Sex 7. Age (In yrs. last birthda; Yrs.	Months Days		in. (Month, Day	(Year)	Coun	rginia
			Usual Residence of Decedent					TED 09	1720		
	rylan	_	10a. State 10b. County	1	0c. City, Town or I	ocation				10	od. Inside City Limits 1 ☐ Yes 2 No
	e Ma	Director	Maryland Ceci	1	E1ktor				10 011	-4.1/15-14-0-1-1	
	with the	<u>i</u>	10e. Street and Number	D4		10f. Zip Code 21921				of What Coun .ted St	
	eath v	Funeral	171 Middlecrof	12. Was Decedent Eve	er in U.S. 13			' (Specify Yes or No- lerto Rican, etc.)		Race - Americ	
0	ifter d or iten		1 ☐ Never Married 2 ☐ Marrie	Armed Forces? 1 ☐ Yes 2 💹 No				erto Rican, etc.)		Black, White, e	etc.
3	ours a	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2MNo				Whi	
2	"natu	lete	15. Decedent' (Specify only highes	s Education t grade completed)	16a. Dec	edent's Usual Occu re kind of work done DO NOT use retire	pation during most of t d)	working	16b. Kind o	f Business/Inc	ustry
717	should be filed within 72 hours after death with the Maryland and Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show umatic event, the "hydical Examiner must be rediffed a	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		lomemaker	<i>a)</i>		In	Her Ow	n Home
2	illed al Hyg other ent,	BeC	17. Father's Name (First, Middle, L	.ast)			18. Mother's	Name (First, Middle,			
<u>a</u>	uld be Menta arked atic ev	To E	William McKinl	ey Miller			Pear1	Irene Ral	kes		
0			19a. Informant's Name/Relationsh	_				Rural Route Numbe		wn, State, Zip	Code)
≥ ນົ	1 and 2 s Health a tem 27 is	1	John E. Cissel	, Sr./Son				, Elkton,		21921 on - City or To	wn State
2	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.		1 Burial 2 ☐ Cremation			position (Name of ematory or other pla	,	ruary		,	
Dallillor	nit. Pa artme ortani injury	1	4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service)			k Cemeter 22. Name and Addre		_2009 nerals, P		vert,	MD
0	Dep Imp		Must. I	lid Clesma	ا ب	licks Home IO3 W. Sta	e for Fu	nerals, P Street, El	.A. kton.	MD 21	921
			23a. Part I. Enter the disease, or shock, or heart failure. List of	complications that caused the		nter the mode of dy	ing, such as car	diac or respiratory ar			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Me	tastatic	Lung	Cance	2		1	Onset and Death UNKNOWN
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):	0					
	LAGIIIIICI	<u>_</u>	Sequentially list conditions,	b. Suprhy for min a	tonesquence of):					_	
	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 10. 20 2 0	orneoqueneo ory.						
ה <u>.</u>	exect an and rial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a c	consequence of):						
00/00	ate be hysicia he bu	lical		d							
ŏ	death certificate be executed e attending physician and d for use as the burial-transit	ician/Medical	IF FEMALE:	23c. If yes, outcome of	prognancy						
Ž D D	eath c attend for us	cian,	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death	B ☐ Ectopic pregnan			23d.	Date of delive Month	ery Day Year
		Physic	1 □ Yes 2 ☑ No 9 □ Unknown	9 Unknown							
, L	The law requires that the ate has been signed by the page 2 should be detached.	by P	Part II. Other significant condition	23e. Did to	23e. Did tobacco use contribute to the cause of death						
ecords,	equire en sig ould b		1 upper 7	ension				_ 1 D Y	es 2□N	2 No 3 Probably 4 Unknown	
e C	2 38 9	Completed	- typut	Lyrodism				— 24a. Was autop	sy i	prior to co	psy findings available mpletion of cause of
I =	: The cate h	Con	Spir	nal Cancer					med? 2 ☑ No	death? 1 ☐ Yes	2 🗆 No
VITAI	Physician: r this certific ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		Ot	her	Death (Check only or			
ō	ding Physician: The In- h. After this certificate ha funeral director, page	7: To	1 ☐ Yes 2 ☐ No 27. Mannex of Death	1 ☐ Inpatient	2 ER/Outpat	of 28c. Inju	4 🗀 Nursir	ng Home 5 MResid			<u>y)</u>
0	nding ath. r: Afte e fune	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	(Month, Day, sation	<i>Year)</i> Injur		rk?]Yes 2 □No				
UNISION	r Atte er dea rectol	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		- At home, farm, (Specify)	street, factory, office		28f. Location (S City or Tow		umber or Rura	I Route Number,
5	ital o Ins aft ral Di										
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	ledical		g Physician: To the best of Examiner: On the basis of e and manner state	xamination and/or						
	To the within To the Somple	Med	29b. Signature and title of sertifier	and marmor orace		29c. Licen	se number			gned (Month,	
) Ja	Elder 8n.		100	02332	2	2.0	24.20	19.
,			30. Name and address of person	who completed cause of dea	ith (Item 23a) (Typ	e, Print)	1-01-		1.000	1	
			O. J SACHI	EUMD (32. Registar)	X6 A, E	Thigh St	tekl	En MD 2	1921	/	
	Sta Registi		31. Date filed (Month, Day, Year)	0 3 2009	see A.	park	9				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 009

Reg. No.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** NNA 0 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9. Birthplace (State or Foreign Gountry) Penns/yVonia at Lak Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 □ Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shot injury or other traumatic event, the Medical Exeminar must be notified at Salisbur 1 Yes 2 No Md Wicomico Director 10g. Citizen of What Country? 10e. Street and Number U.S. 105 Square 180, Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 140 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 7 No BIACK ģ If Yes. Give Specify: 3 Widowed 4 Divorced Year or Dates permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If Item 27 is marked with any injury or wi Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Campbel, Soup Co Elementary/Secondary (0-12) College (1-4or 5+) roduction Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CROPPER UNKNOWN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
32050 Pogwood Lane Laurel, Dec 19956 19a. Informant's Name/Relationship (Type. Print) (SON trederick Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Green acres Mem. PK. 2-14-09 Salisbury 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bewwie Smith at Funeral Sourice Licensee SAlisburgima 2180, FUNETAL Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RANAL BND STAGR DRSRASE **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine rans, leading to introduc cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of signed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ş 2/11/No 3 Probably 4 Unknown cate has been signated by page 2 should by 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 2 1710 1 □ Yes 1 ☐ Yes or Attending Physician: after death. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 SPICIZ 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 2 □ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di **Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO05 8410 2/10/09

• Och

State
Registrar

GHUMP W.

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

COASTAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARL

HOSPICA

P.U Bup 1737 SACis Bruy ans

			1 _ State	epartment of Health and N Certificate of Death		ne . No. 2009	06433
· L		3	Registrar 1. Decedent's Name (First, Middle, Last)	retimodic of Bedin	2. Date of Death	. No.L 0 0 3	3. Time of Death
	Physici /Medic		Charles P. Caplin	nger	February	14 2009	7:00 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Westminster		4c. County of Death	
	Funeral		The Woods At Sun Valley 5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	0 Right	place (State or Foreign
L	Director		409 20 8327 ☐ XM 2□F 89 Yr	s. Months Days Hours Min.	Month, Day, Y Nov. 19,	1919 TN	nry)
	and ww		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location		1	I0d. Inside City Limits
	Maryi -f sho fied a	tor	MD Carroll Westr	minster			1 □ Yes 🌋 No
	or 28a	irec	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coul	ntry?
	ath wi	ral	3830 Baker Road	21157		United Sta	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ XYes 2 □ No If Yes, Give Year or Dates: 1944–46	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton I ☐ Yes 2 XNo Specify: 	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White, Specify:	
0	2 hour aturai	ted b	15. Decedent's Education 16a. D	ecedent's Usual Occupation		b. Kind of Business/In	
215	within 7, iene. than "n h Medi	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of worl ife. DO NOT use retired)	. _		
121	e filed wi al Hygier other th		9 CLa:	ims Processor Super	VISOT Some (First, Middle, Ma		rity Admin.
Maryland 21215-0036	2 should be f and Mental H is marked of raumatic ever	To Be	Marvin Caplinger	Fannie			
lary	2 shou and M is mar aumat	-	1 1 2 1	Mailing Address (Street and Number or Ru			,
	1 and 2 Health tem 27 i			5 W. Old Liberty Rd		Lie, MD 21	
nor	Pages 'nent of hant: if ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	crematory or other place) Lawn Mem. Gard. 2-1		arriottsvi	
Baltimore,	permit. Page Department of Important: if any injury or once.		4 □Donation 5 □ Other (Specify) Crest □ 21. Signature of Funeral Service Licensee	22. Name and Address of Facility			· .
m	any per		I Shew Collins Wight	4112 Old Columbia	Pike Elli	cott City,	MD 21043
В			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Show the term of the t	-			
	Examiner						
	P #	iner	Sequentially list conditions, if any, leading to immediate):			
-	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last):			
8760,	the death certificate be executed y the attending physician and ched for use as the burial-transit	dical E	d				
9	rtificate ng phys as the	0	IF FFINIS				
Вох	leath certific attending p	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Date of deliv	ery Day Year
O.	the de / the a ched f	Physician/M	1 ☐ Yes 22 No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)			
<u>α</u>	n requires that the d been signed by the should be detached	by Pł	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
ord	equire sen siç ould b		Hypertersier, Depressier, Den	enda	1 🗆 Yes	2 No 3 Pro	bably 4.2 Unknown
or Vital Records,	e lan has e 2	Completed			24a. Was an autopsy performe	prior to co	opsy findings available empletion of cause of
lal		e Co	25. Was case referred to medical	26 Place of Doc		No 1 ☐ Yes	2□ No
Ş	S S S	0 B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	T T		ce 6 🖔 Other (Speci	wasst. livg.
D C	ng Phys (fter this ineral di	on: T	27. Manner of Death 128a. Date of Injury (Month, Day Year) 28b. Tir (Month, Day Year)	me of 28c. Injury at work?	28d. Describe how		
Division	Attending r death. ector: After by the fune	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of injury - At home farm	M 1 ☐ Yes 2 ☐ No	28f Location (Stre	et and Number or Run	al Route Number
Dİ	ai or A s after I Direct d in by	Certification:	4 Homicide determined building, etc. (Specify)	i, sites, idetaly, onlo	City or Town,		arriode Harrist,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.				
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month,	
			Debah mange De	H53939		2-16-2	-009
(50		30. Name and address of person who completed cause of death (Item 23a) (T Babak Imance 1, Do; 218 Weshir	ype, Print) is the Heights Med. (Ctr; Wes	tminsky, M	D 21157
	Sta Regist		31. Date filed (Month, Day, Year) 32. Degistrar's Signature FEB 17 2009	Janes Med (

06434

Physic /Med 1 - For State Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Thursini.		1. Decedent's Name (F	irst, Middle, La						2. Date of Deat	h Day Year	3. Time o	of Death	
hysici: Medic/		Jane		Elizabeth		Coste			FEB.	22,2009		3054	
Examin	er	4a. Facility Name (If no Devlin M		ve street and number ursing Hon				r Location of Death erland		4c. County of Dea			
uneral		5. Social Security Numb 245-26-88		Sex 7.A 1 □ M 2 □ √ 7	ge (In yrs. 1	<i>last birthd</i> ay Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sep 2.	9. Bi	rthplace (State ountry) NC	or Foreign	
irector		Usual Residence of De			_				- OCP 2.	2, 1021			
i-f show	tor	MD 10a. State	b. County Alle	gany	10c. Cit	y, Town or L Cu	ocation Imberland				10d. Inside (City Limits s 2 ☐ No	
or 28a	Jirec	10e. Street and Numbe					10f. Zip Code		11	0g. Citizen of What C			
s 23a	rall	10301 C	hristie I		For to U	0 140	Mar Danders of L	21502	anife Van ar Na	US.			
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the modical Examinations and injury or other traumatic event, the modical Examinations are not once.	by Funeral Director	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □		12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	No	rer in U.S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 Yes 2 No Specify:			Rican, etc.)	14. Race - Am Black, Whi Specify:	white		
natura Ical E	ted	15	. Decedent's E			16a. Dec	edent's Usual Occup e kind of work done	nation		16b. Kind of Business			
han "r	Completed	Elementary/Seconda		College (1-4or	5+)	life.	DO NOT use retired nemaker	d)	9	Own Hor	na		
other t	ပ္ပ	17. Father's Name (Firs	st, Middle, Las	t)		ПОІ	Heillakei	18. Mother's Nam	ne (First, Middle, N		iie –		
rked o	To Be	Harolo	d J. Mal	oney				Harrie	et Coltor	1			
27 is ma er trauma		19a. Informant's Name		(Type. Print)	n		ing Address (Street 2.O. Box 6			, City or Town, State, nberland	MD 2	1501	
int: If item iry or oth		20a. Method of Disposi 1 ☐ Burial 2 ☐ d 4 ☐ Donation 5√	remation 3	Removal from State	20b. F	Place of Disp emetery, cre arpelli	position (Name of ematory or other place Funeral Hon	^{се)} ne, Р.А.	2/23/2009	20c. Location - City o Cresapt		MD	
Importa any Inju		21. Signature of Funer	al Service Lice	nsee	,	:	22. Name and Addre Scarp 108 V	ess of Facility elli Funeral H 'irginia Avenu	lome, PA le: Cumberla	and, MD 21502			
		23a. art Ent the c	disease, or cen	nplica i ns that cause one caus on each	d the deat	h. Do not e	nter the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approxima	etween	
sician ledical		23a. art Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death disease or condition resulting in yearth) Approximate Interval Between Onset and Death Disease or condition a. The to (or as a consequence of):											
miner		Due to (or as a consequence ot):											
##	iner	Sequentially list condition if any, leading to immercause. Enter Underlying that initiated events	ions, diate ng	Due to (or a	s a conseq	uence of):							
and al-trans	Examiner	that initiated events resulting in death) Last	t I	c Due to (or a	s a conseq	uence of):					1		
nysiciar he buri			- (d								_	
attending physician and for use as the burial-transit	cian/Medical	IF FEMALE: 23b. Was decedent pro in the past 12 mo	nths?	23c. If yes, outcom 1 ☐ Live birth	2 Feta	egnancy Fetal death 3				23d. Date of delivery Month Day Year			
by the ached	Physic	1 ∐ Yes 2 ∐ N 9	0	9 Unknown									
igned be det	by P	Part II. Other significa	nt conditions	contributing to death	but not res	ulting in the	underlying cause giv	ven in Part I.		oacco use contribute es 2 □ No 3 □ F			
peen s	Completed by	SEVEK	12 /		((/	3,	/ 3/0	-1103/3	4	1	023		
e has ige 2 s	Jdw								24a. Was a autops perforr	prior to med? death?	autopsy finding completion of	cause of	
rtificat tor, pe	Be	25. Was case referred	to medical					26. Place of Dea	1 □ Yes th (Check only on	2 ☑1√0 1 ☐ Ye e)	s 2⊡Ño		
his ce I direc		examiner? 1 ☐ Yes 2 ☑ ⊀6		Hospital: 1 ☐ Inpa	tient 2	ER/Outpati	ent 3 DOA Oth	ner: 4 Nursing H	ome 5 🗌 Reside	ence 6 □Other (Sp	ecify)		
After t funera	ion:		5 Pending	28a. Date of Ir (Month, L		28b. Time Injury	Wo	ryat″ k?]Yes 2∐No	28d. Describe ho	ow injury occurred			
Director: in by the	Certification: To	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigatio 6 □ Could not determine	be 28e. Place of I	njury - At he etc. <i>(Speci</i> i	ome, farm, s fy)	street, factory, office	ires Z No	28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Nu	ımber,	
To the Functor Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical Ce				of examina					cause(s) and manner late and place, and du		(s)	
To the comple	Med	29b. Signature and title	e of certifier	2	21	1	29c. Licen	se number	2	29d. Date signed (Mor	oth, Day, Year)	29	
		30. Name and address	s of person who	o completed cause of	death (Iter	n 23a) (Type	e, Print)	J5700.	1	720	/ 200	- / .	
		Shir C.	Khar	ma min	12	121 1	Natro	nal Iti	ghwa	y Laval	emd	21502	
Sta Registi		31. Date filed (Month,			trar's Signa	turo	ale		-				
egioti	-ari	A	R 0220	NY JUNE	w f	19							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Charles A. G. Dehne ebruan

Months

10f. Zip Code

4b. City. Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Days

Glen Burnie

Hours

Min.

5:50 A

Birthplace (State or Foreign Country)

10d Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2X No

Maryland

4c. County of Death

10g. Citizen of What Country?

Specify:

Race - American Indian, Black, White, etc.

23d. Date of delivery

Day

Year

Month

White

8. Date of Birth (Month, Day, Year)

Feb. 26,1912

Anne Arundel

Physician /Medical Examiner

Funeral

Director

with the Maryland

death v

Baltimore, Maryland 21215-0036

1 - For State Registrar

10a. State

MD

5. Social Security Number

212-09-8455

10e. Street and Numbe

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

10h. County

Anne Arundel

Baltimore Washington Medical Center

1 XM 2 □ F

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at and 2 should be

Physician /Medical Examiner

permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any Injury or other traionce.

Physician: The law requires that the death certificate be executed burial-tran nding physician use as the burial nse atten 0 signed by the a page 2 s certificate this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral To the Hospital or Attending

Box 68760.

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of Vital Records,

Division

Director 621 Cypress Road 21146 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Machinist Koppers Company 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Dehne ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald C. Dehne/ Son Essex, 1001 Foxridge Lane MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb. 16, Loudon Park Cemetery Baltimore, MD 2009 Barranco & Sons, P.A. Severna Park Funeral Home 21, Signature of uneral Service Lice 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Pgr.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Failure Immediate Cause (Final Duges disease or condition resulting in death) Due to for as a consequence of: diou Sequentially and conclined in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy In the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy perform 1 ☐ Yes 25. Was case referred medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a, Certifier and manner stated. 29b. Signature and title of certifier

7. Age *(In yrs. last birthday)* **96** Yrs.

10c. City. Town or Location

Severna Park

Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗹 No 2 No 1 ☐ Yes Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Hospital Drive, GlenBurnie MD. 21061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) edvae 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Elwood Dent** February 2009 2019 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery Washington Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 65 Yrs. Maryland September 2, 1943 218-38-7214 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 1 ☐ Yes 2 X No Calvert Lusby 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20657 440 Coster Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No If Yes, Give Year or Dates Specify Specify. 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Blanche Elizabeth Gough Cephas Dent 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Aretha Walls - Niece 670 Bafford Road, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Mt. Gethsemane Chr. Cem. 2/14/2009 Huntingtown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bladen Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) NDOCARIMTIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisease or injury that initiated events resulting in death) Last VASCULAR ACCIDENT RENAL DISTAME yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed STERUM INFERTION 1 ☐ Yes 2 🔼 No 1 □ Yes 2 X No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Propatient 2 ER/Outpatient 3 DOA 27. Manner of Death

Physician /Medical Examiner

certificate be executed

Box 68760,

P.0.

Division of Vital Records,

or Attending

Hospital

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be i

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MD

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27 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, 1m Wedies Exs. air or must be a cylified at

permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygin Important: If item 27 Is marked other any injury or other traumatic event.

Saltimore, Maryland 21215-0036

Examiner Physician/Medical

ourial-transi physician the use as t the signed by the Completed by page 2 s certificate has Be Certification: To After this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 Unknown

25. Was case referred to medical examiner? 1 Yes 2 No

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

31. Date filed (Month, Day,

28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier

5 Pending investigation

6 □Could not be

determined

29c. License number
D-5d28 U

29d. Date signed (Month, Day, Year)

Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAMIM, HD, WASHINGTON ADVENTUT MSPT, TAKOMA PARK

32. Registrar' Signature

		For	State of Ma	aryland	l / Depa	ırtme	nt of Hea	alth and I	Mental Hy	giene			
	•	1 - State Registrar			Cer	tifica	te of De	eath		Reg. No.	2009	064	37
Physicia	n	1. Decedent's Name (First, Middle	, Last)						2. Date of De Month	Day	Year	3. Time of Dea	ath
/Medic			DeGRAFFENE	REID,	JR				FEB.		2009	0310	М
Examin	er	4a. Facility Name (If not institution		IIoan		4b. City		cation of Death			County of Death	EDV	
Funeral		Shady Grove 5. Social Security Number	6. Sex 7. Age		st birthday)			Under 24 Hrs.	8. Date of Bi	rth	IONTGOM 9. Birth	EKY place (State or Fo ntry)	oreign
Director		251-20-9815	1 XM 2 ☐ F	81	Yrs.	Months	Days H	Hours Min.	Aug.1	7,19		<u>Carolir</u>	na
pur 🔉		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Loc	cation						10d. Inside City L	imits
Maryla f sho	ō		tgomery	, ,	Rock		lle					1 □ Yes 2 §	⊋ No
r 28a	Director	10e. Street and Number					ip Code			10g. Citi	zen of What Cou	ntry?	
h with		14635 Bauer	Drive, #11	.2			2085	3		U	S.A.		
ified within 72 hours after death with the Maryland Hygiene. Hygiene within 12 hours after death with the Maryland stherms 23a or 28a-f show ent, the Marsteal Examination in 181 by motified at	Funeral	11. Marital Status	12. Was Decedent B Armed Forces?		. 13. V	Vas Dec f Yes, sp	edent of Hispa ecify Cuban, I	anic Origin? (S Mexican, Puerto	pecify Yes or No Rican, etc.)	D-	14. Race - Ameri Black, White,		
S afte	by Fi	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	1	□Yes	2 N O 5	Specify:			Specify: B1	ack	
hour		15. Deceden			16a. Deced	lent's Us	ual Occupatio	n		16b. Kii	nd of Business/Ir		
hin 72	plet	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4or 5	i+)	(Give I life. E	OO NOT	use retired)	ng most of wor	king			Highway	7
ygien ygien er th	Completed	6th				E	lagma				Commis	sion	
be file	Be	17. Father's Name (First, Middle,	·	a .					ne (First, Middle		Surname)		
n y re	ဥ	R11ey DeGr 19a. Informant's Name/Relations	affenreid,	Sr	10h Mailin	a Addre			enders		r Town, State, Zi	n Cade)	_
nd 2 s lifth an 27 Is i		Gail Whitley		.)		-				-	hersbu	200	379
es 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene. I death and Mental Hygiene. I file marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Mardeal Examination is set to notified at		20a. Method of Disposition		20b. Pla	ace of Dispos metery, crem	sition (N	ame of	1	Date		cation - City or To		
Pag Tent ant: I		H Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			Olive	et (Cemete				derick		
permit. Departr Imports any inju	(21. Juga fure of Funeral Service	License	1. /	,							OME, P.	
205 20	1	resorge T	Siona	any							ville,	MD20850	
	9	23a. Part 1. Enter the disease, or shock, or heart failure. List	only one cause on each lir	i the d e ath. ne.	Do not ente	er the m	ode of dying, s	such as cardiad	or respiratory a	arrest,		Approximate Interval Betwee Onset and Dea	en th
Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Sepsi			ary	to Ur	inary	Tract	Inf	ection		
Examiner						. 4 7 .							
- T	ner	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. Respi	a conseque	TY I'c	1441	ire						
acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с										
te be executed /sician and e burial-transit		resulting in death) Last	Due to (or as	a conseque	ence ot):								
9 8 5 5	edical		d										
eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of deliv	rery	
death death e atte	icia	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic Other (pregnancy specify)				Month	Day Yea	r
at the de	hys	9 ☐ Unknown	9 Unknown										
res tha signed be det	þ	Part II. Other significant condition	ns contributing to death b	ut not resul	ting in the ur	nderlying	cause given i	n Part I.				the cause of deat bably 4 ➡ Unk	
w requir s been s should	Completed												
le law has l	шр								24a. Was auto perf			opsy findings ava ompletion of caus	
in: The ifficate or, page	e Co	25. Was case referred to medica					26	Riggs of Dec		≱∏No	1 □Yes	2 □ No	
Physician: The le	0 0	examiner? 1 Yes 2 No	Err or r	ent 2 🗆 E	ER/Outpatien	nt 3 🗔 I	1				6 □Other (Spec	ifv)	
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or Att fter d jrect in by 1	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ury - At hor c. <i>(Specify</i> ,	ne, farm, stre)	eet, facto	ory, office			(Street an wn, State		al Route Number	i
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as to		29a. Certifier X Certifyii	ng Physician: To the best	of my know	vledge death	n occurre	ed at the time.	date and place	and due to the	e cause(s) and manner as	stated.	
e Hos 124 h e Fun letely	edical		Examiner: On the basis o and manner sta	f examinati									
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		•	For State Registrar	or Maryland		artment of Heritificate of E			giene Reg. No.2	009	06438
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
# 180	/Medic		Gail Dana Griner			4h Cih. Taura an	Leasting of Dooth	Feb.		009 unty of Death	1:21 p M
)	Examin	er	4a. Facility Name (If not institution, give street and n			4b. City, Town, or		ols.		-	+
	Funeral		Calvert Memorial Ho 5. Social Security Number 6. Sex	7. Age (In yrs. k	a <i>st birthd</i> ay)	If Under 1 Year_	Frederi If Under 24 Hrs.	8. Date of Birt (Month, Da	h	alver 9. Birthp	blace (State or Foreign ntry)
В	Director		299-05-3448 11√2 M 2□F	92	Yrs.	Months Days	Hours Min.	3/16/	1916		hio
	put »		Usual Residence of Decedent 10a, State 10b, County	10c. City	, Town or Lo	ocation				T.	Od. Inside City Limits
	//aryla	ō					-				1 X Yes 2 No
	the N 28a-	Director	MD Calvert 10e. Street and Number			Dunkirk 10f. Zip Code			10g. Citizen	of What Cou	ntry?
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	ems 2	Funeral		cedent Ever in U.S	S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)		Race - Americ Black, White,	
5-0036	should be filed within 72 hours after death with the Maryland Mently Hygiene, and Mently 1 Hygiene, and Mently 1 Hygiene, and Mently 1 Hygiene, and Mently 1 Hygiene, and Medical Examiner must be notified at matte event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes (1 Yes, 0 Year or	No Bive Dates:		1 □ Yes 2 💢 No	Specify:			pecify: W	Thite
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5	filed w Hygie other t	ပ္ပ	17. Father's Name (First, Middle, Last)			Engineer	18. Mother's Name	e (First, Middle,		ctroni	CS
and	be pe od o	o Be	Carl Griner				Rhoda	Humber	stone	, 	
Ž	2 should and Men Is marke aumatic	으	19a. Informant's Name/Relationship (Type. Print)		19b. Maili	ng Address (Street a					Code)
	nd 2 alth a 27 ls		Marguerite Griner/Wi	fe	9436	Howes R	oad, Du	nkirk,	MD	20754	
ore,			20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from	20b. P	lace of Disperent	osition (Name of matory or other place	θ)	Date	20c. Locat	tion - City or T	own, State
altimore,	Pages ment of I ant: If Ite lury or o		4 □ Donation 5 □ Other (Specify)			ake Crem		5/2009	Belt	svill	e, MD
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee			2. Name and Addres	I/ C	ymond			, P.A.
	70 = @ 0		220 Part 1 Enter the disease or complications the	t caused the death		O Box 43				20754	Approximate
		8 .	23a. Part1. Enter the disease, or complications tha shock, or heart failure. List only one cause or Immediate Cause (Final	each line.		Ter the mode of dying		or respiratory a	11631,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition	(or as a consequ	_	mal t	ailur	e			one welk
	Examiner			arcin	10000	Col	500			4	Serprod
į,	7 ×	ner	Se uentially list conditions it any, leading to immediate cause. Enter Underlying	o (or as a consequ	ence of):						minutes.
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	The law requires that the death certi ate has been signed by the attending page 2 should be detached for use a	Physician/M	in the pact 12 months?	e birth 2 Feta gnant at time of de		□Ectopic pregnancy □ Other <i>(sp</i> ec <i>ify)</i>				Month	Day Year
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	res thighed	by F	Part II. Other significent conditions contributing to	death but not resu	ulting in the u	underlying cause give	en in Part I.	23e. Did 1			the cause of death?
orc	w requir been si should I	ted	New weregove	•							,
3ec	e law has b	Completed	rieumima.					24a. Was auto		24b. Were aut prior to co death?	opsy findings available ompletion of cause of
a	iclan: Th certificate rector, pag		25. Was case referred to medical	•			00 84 (8	1□ Yes	\$ZINO	1 ☐ Yes	20 No
₹	sicla certi	o Be	examiner?	Inpatient 2□	FB/Outpatie	ent 3 DOA Othe	26. Place of Deat er: 4 ☐ Nursing Ho			Other (Spec	(6/)
10	g Physical this leral dil	n: To	27. Manner of Death 28a. Da	te of Injury onth, Day Year)	28b. Time			28d. Describe		. ,	97
ion	ath. or: After	atio	2 Accident investigation	Jilii, Day Teai)	mjury		Yes 2□No				
Division or Vital Records,	or Atte ter de Ilrecto n by th	Certification:		ce of injury - At ho Iding, etc. (Specif		treet, factory, office		28f. Location (City or To		Number or Rui	al Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1X CertifyIng Physician: To	the best of my kno	wledge, dea	th occurred at the tin	ne, date and place,	and due to the	cause(s) ar	nd manner as	stated.
	ne Ho ne Fui pletely	Medical	(Check only 2 Medical Examiner: On the and m	basis of examina anner stated.	tion and/or i	nvestigation, in my o	pinion, death occur	rred at the time	date and pl	lace, and due	to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier			29c. License	_		29d. Date	signed (Month	, Day, Year)
			Lalumjons	any	M) 1)0	027189	7	d	141-	2009
10	(n)		30. Name and address of person who completed ca		23a) (Type	, Print)	1289	WAL	DAD F	= , M/	22604
df	(M 10 Sta	ite	31. Date filed (Month, Day, Year) 32	Registrar's Signa	ture			. , , ,	2010	/ 14(1)	-1289
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06439 State of Maryland / Department of Health and Mental Hygiene? $\bigcap \bigcap G$ For State Registrar Amended#31perFCHD Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14 2009 Month **Physician** Dorothy D. Dinnis February 5:56p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Country Meadows Assisted Living Frederick Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Funeral Yearl Months Days Hours 1 ☐ M 2 🕱 F Director 579-20-1170 84 July 3, 1924 Massachusetts Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
and: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Experime rivest be recitled at my or other traumatic event, the Medical Experime rivest be recitled at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director 1 ☐Yes 2X No Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5957 Quinn Orchard Road 21704 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🔀 No Specify: <u>Ş</u> Specify: 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John Griffin Eva Rossetti 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24900 Old Hundred Road Dickerson, Maryland 20842 Patricia A. Tyler / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State February permit. Page Department of Important: If any Injury or once. 19, 20094 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) OSSTRUCTIVE 1 month Chronic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ty pertension. 1XIYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diabetes mplitus 24a. Was an autopsy 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) BOTTICE Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living Frait 2 No Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) my death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Division of Vital Records,

P.O. Box 68760,

21215-0036

Baltimore, Maryland

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day Thomas onth, Day, Year) Thonsen
Registrar's Signature

D51643

State Registrar 31. Date filed (Month, Day

FEB 1

Year)

7 2009

Idwsartown

555 W.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

CW.

3/2. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🤈 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 11 2009 **Physician** 5:50 A Bessie May Dawson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Egle Nursing Home Lonaconing Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yea. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 □ F 235-30-0088 38 July 24 1920 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene Important: If item 27 is merked other than "natural" or items 23a or 28a-f show any fijury or other traumatic event, the Medical Evantmer must be nutified at Jones. Yes 2 No w. Mineral Keyser Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 152 Mozelle St. 26726 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify. ò 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Housework unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Junkins Myrtle Dixon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Scott Dawson JR/son 152 Mozelle St, Keyser, West Virginia 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 02/12 cemetery, crematory or other place) Cumberland Crematory 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Cumberland Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sudden Car diac disease or condition resulting in death) /Medical Examiner CORON ARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exam ng physician and as the burlal-tran Due to (or as a consequence of) Physician/Medical ours after death. erel this certificate has been signed by the attending filled in by the funeral director, page 2 should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☑No 9 Unknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown MIENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed Hospital or Attending Physicien:

death

filed within 72 hours after

Pages 1 and 2 should be

altimore, Maryland 21215-0036

e Funerel Direc within 24 hou To the Funer completely fil Medical ဂ္ဂ

29a. Certifier Fig. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicei Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

D 26907

FEBRUARY 11 2009

High

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Harjit Sidhu, 925 Bishop Walsh, Cumberland, Maryland 21502

State Registrar

31. Date filed (Month, Day, Year) FEB 1 2 2009

4 ☐ Homicide

32. Registrar's Signature

	1 - State Registrar		f Maryland / D	Certificate of		,		9 0644
ysician Medical	Linne	ette Baile					ry 13, 20	
caminer	4a. Facility Name (If not institut Woodside Cent			4b. City, Town, o	r Location of D		4c. County o	f Death tgomery
neral ector	5. Social Security Number 220-60-6481 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🗓 F	7. Age (In yrs. last birth	nday) If Under 1 Year Months Days	If Under 24 H	lin. (Month, Da	rth ay, Year) 17,1919	9. Birthplace (State of Formatry) We Jamaica, Ind
led at tor	10a. State 10b. Coun	ntgomery	10c. City, Town o	or Location Lver Spring				10d. Inside City I
Director	10e. Street and Number		011	10f. Zip Code	1		10g. Citizen of Wh	1527
ral [Street		2091	0		United	States
imatic event, the Medical Examinar must be notified at To Be Completed by Funeral Director	3 X Widowed 4 ☐ Divorce	Armed For 1 ☐ Yes	e Z	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 X No		(Specify Yes or No lerto Rican, etc.)		- American Indian, White, etc. Black
rt, the Medical E	15. Decede (Specify only high Elementary/Secondary (0-12) 8th grade	ent's Education nest grade completed) College (1-	4or 5+)	Decedent's Usual Occup Give kind of work done life. DO NOT use retire	during most of v d)	working	16b. Kind of Busi	•
F S	17. Father's Name (First, Middle			Housekeepe			Domes	
atic even To Be		,				lame (First, Middle,	, Maiden Surname))
aumat	19a. Informant's Name/Relation		19b. N	Mailing Address (Street	Ada and Number or	Gaynor Rural Route Number	er. City or Town S.	tate Zin Code)
any Injury or other traumatic once.	Robert S. Wald 20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other 21. Signature of Juneral Service	n 3 □ Removal from S (Specify)	20b. Place of D cemetery,	Disposition (Name of crematory or other place Washingtor	Fek Cemete	o. ^{Dal} e, 09	20c. Location - C Adelphi.	
등장	Dandy	ph By	orto	Inc.;600 K	ennedy :	Street, N.	W.;Washir	ngton,D.C.2
	23a, Part 1. Enter the disease, shock, or heart failure. Lis	or complications that ca	used the death. Do not					
ian ical	Immediate Cause (Final disease or condition resulting in death)	-a. Pne	umonia		ng, such as card	iac or respiratory ar	rrest,	Onset and Dea
ical ner <u>b</u>	Immediate Cause (Final disease or condition resulting in death) Seguentially list conditions	a. Pne Due to (o	umonia ras a consequence of):	al Faile	11C		rrest,	Onset and Dea
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State Registrar Lakshmi

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

MD

32. Registrar's Signature

Washington Derect.

Vaid yangthan

FEB 2 3 2009

Division or Vital Records, P.O. Box 68760,

21215-0036

,610h Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland	•	rtificate of		лептат тус ғ	gierie Bea. Na	2009	06444
			Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ıth		3. Time of Death
	Physicia /Medic		Elaine Ann	Dudash				Februar	y 2	2, 2009	1300 P M
	Examin		4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, o	r Location of Death		40	c. County of Death	
•"			Homewood Retireme 5. Social Security Number 6. Sex	ent Village 7. Age (In yrs. la	set hirthday)	William If Under 1 Year	sport If Under 24 Hrs.	8. Date of Birtl	h	Washingto	olace (State or Foreign
	Funeral Director		1 🗆 1	M 2 1 7. Age (III y is. ia	Yrs.	Months Days	Hours Min.	Jan. 19	v, Year,) Coul	sylvania
	ō		195-30-0552 Usual Residence of Decedent					Julie 12			
	show		10a. State 10b. County	10c. City	Town or Lo	cation					0d. Inside City Limits 1 ☐ Yes 2 No
	8a-f	Director	Maryland Washington	n Will	iamspo	10f. Zip Code			10a C	itizen of What Cou	
	with the	١	10e. Street and Number			21795				S.A.	itry:
	ns 23	Funeral	16650 Virginia Ave	. Was Decedent Ever in U.S	13.		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		14. Race - Ameri	
9	after o		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	1	f Yes, specify Cuba 1 □ Yes 2 No	an, Mexican, Puerto Specify:	Hican, etc.)		Black, White, Specify:	etc.
21215-0036	be filed within 72 hours after death with the Maryland tital Hyglene. od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	3 Widowed 4 □ Divorced	Year or Dates:					101 1	Wh:	ite
15-("natu	Completed	15. Decedent's Educa (Specify only highest grade of	completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ing	16b. r	Kind of Business/In	dustry
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b	e filed al Hyg other vent, I	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maidei	n Surname)	-
ylar	should be nd Mental marked o	70	Paul Richard Smit	th	,		Anne	Kathryh		Miller	
lar	2 should and Miles mark		19a. Informant's Name/Relationship (Type	e. Print)		,	and Number or Rur				*
e, l	t and 2 Health em 27		Mike Dudash 20a. Method of Disposition	20h Pl	4064			Sharps		g Marylan	
Baltimore, Maryland	permit. Pages 1 and 2 should I Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic once.		1 ☐ Burial 2 ☐ Cremation 3 🗷 Re	moval from State	metery, crer	sition (Name of natory or other place	rado 03/0	i		,	
Ħ	nit. Partme artme ortan injuri		4 □ Donation 5 □ Other (Specify) 21. Sign up of Funeral Service Deensee		22	2. Name and Addre	ess of Facility Res	t Haven		ora, Col	
B	permi Depa Impo any ir		15 6	12							yland 21742
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one	ations that caused the de th	. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
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	uted d ansit	Examine	Cause (Disease or injury								
ó	an an	Exa	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):						
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Box	death certi e attending d for use a	Physician/M	in the past 12 months2	c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		1	23d. Date of delive Month	ery Day Year
o.	the de y the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown							
о, С	Physician: The law requires that the dethic certificate has been signed by the all director, page 2 should be detached	by Pł	Part II. Other significant conditions conti	ibuting to death but not resu	Iting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco	use contribute to	he cause of death?
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Vita	Physiclan: r this certific ral director,	Be	25. Was case referred to medical examiner?	spital:		ot all pos Oth	26. Place of Deat	,			
ō		. To	1 Yes 2 No	28a. Date of Injury	28b. Time o	f 28c. Inju	ry at	ome 5 ∐ Resid 28d. Describe h		6 ☐ Other (Specurry occurred	f(y)
ion	nding Ph ath. r: After thi e funeral	atior	f Hatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	Injury	M 1 🗆	rk?]Yes 2 □ No				
Division	r Atte er deg recto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tox		and Number or Rur te)	al Route Number,
Ξ	italon Insaftural Din Iledin	Cer								·	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	Medical		cian: To the best of my knowner: On the basis of examinate and manner stated.							
	To the within 2 To the comple	Mec	29b. Signatury and title of destifier	and mariner stated.		29c. Licen:	se number		29d. D	ate signed (Manth	Day, Year)
	->-0		> Malla	Micsica Di	154	1 1)	DOC			7/23/h	09
			30. Name and address of person who con	npleted cause of death (Item	23a) (Type,	Print)	. 100	1/		1 11.1	600
			STEPHEN E- METER	on un BY	24 /2	Hu,	76101	10000	100	en ma	21747
	Sta Registr		31. Date filed (Month, Day, Year)	(32. Registrar's Signat	ure	- 42.0	·				
	negisti	all	M 4 D O 2 2000	CARROLL R	7. 15.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 19 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 0035 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Noonico 5AL156114 MEDIAL TENINSULA REGIONAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 □ M 2 😿 F 217-90-Director Marylano Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f shor 1 Xes 2 No Funeral Director icomico 10g. Citizen of What Country? 10e. Street and Number 21804 venue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Grelue Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file.
Dipartment of Health and Mental Hygn Important: If Item 27 is marked any Injury or other to going. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type! +USBGnd 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 91 Service Licensee 22. Name and Address of Facility , Isabella Smith F. H 07 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Divease Laterstitial **Physician** /Medical ue to (or as a consequence of): Examiner Sporte Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or se a consequence of): ending physician and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 ned by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 pronths?
1 Yes 2 No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 9 I Unknown 10 the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>}</u> Sté 4 Unknown 3 ☐ Probably 1 Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 2 No 1 ☐ Yes I or Attending Physician: after death. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 TNo 1 Inpatient 2 ER/Outpatient 3 DQA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 □Yes 2 ∏No investigation 2 ☐ Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide e Hospital of 24 hours at Euneral D 1 Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 63199 02/12/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY, MD. 21804. SHORE DE YOGESH VOHEM 614 EASTERN Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 3 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06446 State of Maryland / Department of Health and Mental Hygien 2009 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 1220AM **Physician** 09 Laylene Dot son 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs University of Maryland Medical Center None 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 49 July 28, 1959 Maryland Director 216-70-0035 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo Frederick Maryland | Frederick 10g. Citizen of What Country? 10e. Street and Number ō Items 23a 21701 United States 303 Catoctin Avenue by Funeral and 2 should be filed within 72 hours after death vealth and Mental Hygiene. • To is marked other than "natural", or Items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No **Black** Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Nursing Assistant Assisted Living 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Albert Dotson, Sr. Anna Mae Myers ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau 303 Catoctin Avenue Frederick, Maryland 21701 Joseph Eyler / Companion 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) February 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 14, 2009 4 Donation 5 Other (Specify) Olivet Cemetery Frederick, Maryland 21. Signature of Funeral Service Licensee Stauffer Funeral Homes, E. Ridgeville Blvd Mt. Airy, Maryland 21771 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Intra-Abdominal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Vear 5 Other (specify) 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Division 5 ☐ Pending investigation s after dea... al Director: Aff 1 ☐Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide hours a 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MI) Iruona 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St Baltimore, Hanh 21201

State

Registrar

31. Date filed (Month, Day, Year)

FEB

32. Registra's Signature

2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year **Physician** 11:10P M 14, 2009 LADELLE VIRGINIA DANIELS February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Somerset 23182 Church Lane Wenona If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔀 F 1923 Director 85 May 8, Maryland 214-36-7292 Usual Residence of Decedent death with the Maryland 10c City Town or Location 10d. Inside City Limits 10a. State 10h County or 28a-f show other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2 No Maryland Somerset Wenona 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21870 23182 Church Lane USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or iter 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Walter Clifton Webster Annie May Horner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) 23182 Church Lane - Wenona, MD 21870 Arthur S. Daniels, Jr. permit. Pages 1 and Department of Healt Important: If Item 2: any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Paul's Cemetery 2/18/2009 Wenona, Maryland 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 21. Signature of Funerar Service Ficenses 1306 W. Main Street - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** multion the state of): disease or condition resulting in death) /Medical Examiner notin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) P.O. Box 68760, nding physician Hospital or Attending Physiclan: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 N → 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy chionic performe vach 1 □ Yes 2 HNo 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending hours after death. uneral Director: Af ely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 🛮 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 15384 RODWEY A. WENRICH, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1346 S. DIVISION 31. Date filed (Month, Day, Year) egistrar's Signature State FEB Registrar

Physician /Medical Examiner Examiner The law requires that the death certificate be executed

Department of Important: If any Injury or once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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it of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the M

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

burial-tra the attending pl been signed by the should be detached s certificate has be irector, page 2 s To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Physician/Medical

Be Completed by

Certification: To

Medical

Division or Vital Records, P.O. Box 68760,

1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant at time of death 5 ☐ Oth 9☐ Unknown	er (specify)		Month Day Year
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			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing Hon	ne 5 Residence	3 ☐Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Work?	8d. Describe how injur	
3 Suicide 6 Could not b 4 Homicide determined		actory, office	8f. Location (Street an City or Town, State	d Number or Rural Route Number,)
29a. Certifier (Check only one)	nysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, a gation, in my opinion, death occurre	and due to the cause(s) and at the time, date and	and manner as stated. I place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. Dat	e signed (Month, Day, Year)

D51735

State Registrar 31. Date filed (Month, Day, Year)

Frederick Delboy,

6602 Church Hill Rd. Chestertown, MD. 3 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Mary Kipe Elliott February 2009 Year 0043 **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (Month, Day, X Sept. 16 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 5^{ea} 1924 Hours Min. Months Maryland 1 □ M 2 🖫 F 84 217-24-7435 Director Usual Residence of Decedent City, Town or Location
Telephones Island 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Calvert 1 ☐ Yes 2 No Director 10g. Citizen of What Country? United States 10f. Zip Code 20615 10e. Street and Number ō 8535 Patuxent Ave. 23a Funeral items : 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☐ No Specify: White Specify. þ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Public School Teachers Aide is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ada Powell Edward Virgil Kipe မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 8535 Patuxent Ave. Broomes Is. MD 20615 H.C. Elliott- husband Feb 13 2009 al Service 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Metropolitan Funeral 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner lure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed emio Due to (or as a consequence of): physician ar s the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical ena 0 attending p for use as t IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown Year Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown s been signed by should be detact Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 4 Unknown 2 🗌 No 3 ☐ Probably 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 sl 2] es 0 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∏Yes 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After t 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier **Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and Itle of certifier D006022 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dRW 10 M.D. LOOI HAMLETTE STEVEN 32. Registrar's Signature 31. Date filed (Month. Day, Year) State Registrar CARLA

y Catherine Elin	1- For State	St	ate of Maryland		artment of <i>rtificate of</i>		and Me	ntal Hy			009	0645
Physician edical Examine		s Name (First, Middle LY CATHER							2. Date of De	eath Day Yea 20, 2009		me of Death 959 hrs
	4a. Facility N		n, give street and number)		4	b. City, Town	n, or Locatio	n of Death	rebruary	4c. County of		
Funeral Director	5. Social Sec 215-79			e (In yrs. I	ast birthday) Yrs.	If Under 1	Year If Un Days Hou	nder 24Hrs. urs Min.	1		9. Birthplac	
, un		ence of Decedent	W 2A		, Town or Location	on			3011	10, 2007	'	Inside City Limits
Maryland 28a-f show any datonce.	MARYL	ND CAROL	INE	PI	RESTON							Yes 2 X No
the Maryland a or 28a-f sh tiffed at once	10e. Street a		WOODS DRIVE			10f. Zip Coo				10g. Citizen of Wh		es.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once, To Be Completed by Funeral Director.	11. Marital S 1 X Never	tatus Married 2 Ma wed 4 Dive	12. Was Decedent Armed Forces? 1 Yes 2 orced fryes, Give Year or Dates:	X No	If Ye	S Decedent or Ss, specify Cu	f Hispanic O uban, Mexica No. specii	an, Puerto I fy:		lo- 14. Race White Specify:	- American Ir e, etc. WHITE	ndian, Black,
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AD 2 2 shoul th and N 27 is m	-	J. ELIN/E	, , ,,							PRESTON,		
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Balti permit Depat an Importa		of Funeral Service			²² FE	LLOWS,	ress of Each HELF H LIB	ENBEI	N & NE	WNAM FUN	ERAL H	OME, P.A. MD 21617
Physician /Medical xaminer	failure. I Immediate C	nter the disease, or ist only one cause ause (Final disease esulting in death)	conplications that caused on each line. a. Sudden u Due to (or as a conse	nexp	. Do not enter th ected de	e mode of dy	ing, such as	cardiac or	respiratory a	rrest, shock, or hea	art Ap	proximate Interval etween Onset and Death
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60, e be executed ysician and burial - transit	Xunpe	NDED	d. X AMENDED #5	per	FH g890 28a-f.pe	4/22/	09 TT	/7/00	TT		-	-5
Division of Vital Records, P.O. Box 68760, ospital or Attending Physician: The law requires that the death certificate be executed hours after death unreral Director: After this certificate has been signed by the attending physician and ly filled in by the funeral director, page 2 should be detached for use as the burial - transi Certification: To Be Completed by Physician/Medical E.			23c. If yes, outcom	ne of preg	nancy 2 Fet	al death er (Specify)		pic pregnar		23d. Date of Month	delivery Day	Year
i, P.O. E ires that the signed by the be detached d by Ph		significant conditi	ons contributing to death	but not re	esulting in the ur	nderlying cau	se given in l	Part I.	1	tobacco use contri	_	
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To the Hos within 24 h To the Fun completely			ysician: To the best of my niner: On the basis of exam and manner stated.									se(s)
F ≋ E ≅	29b. Signatur	and title of certifier					ense numbe	er		29d. Date signe February 2		ay, Year)
	1	address of person v	who completed cause of de D Assistant Medic	,		Penn Str	eet, Balti	more, M	D 21201			
State Registrar		(Month, Day, Year) FFR 2.5	2009 32 Registrar	s Signatu	bar	w.						

Amended #19a, nls, 02/17/09, Allegany Co. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland / Department of Health and M 1 - State Registrar Certificate of Death		leg. No.	06451
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day Ye	NA NA
	/Medic	al	MARY T • FINSTER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	FEB.	13, 20 4c. County of D	09 2000
	Examin	er	ALLEGANY CO. NURSING & REHAB. CTR. CUMBERLAND		ALLEG	
T	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
	Director		232–44–8694 1 M 2 NF 79 Yrs. Months Days Hours Mill. Usual Residence of Decedent	JULY 17	, 1929 WE	ST VIRGINIA
	low at		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-fsh iilied	ctor	WV MINERAL RIDGELEY			1 □ Yes 2 No
	or 28	Director	10e. Street and Number 10f. Zip Code	1	10g. Citizen of What	Country?
	eath v		ROUTE 2, BOX 668-E 26753 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	U.S.A.	merican Indian,
0	172 hours after death with the Maryland "natural", or Itams 23a or 28a-1 show olical Examiner must be notified at	Funerai	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, W	/hite, etc.
5-0036	ours a	d by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates: If Yes, Give Year or Dates: 1 □ Yes 2 No Specify:			WHITE
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<u>yla</u>	Men Men arke	To E		r. JENKI		
Maryland 2	2 6 7 8	1	19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura 19th HOTT			1
	is 1 and 2 of Health Itam 27 other tr			Date	Y WV 26 20c. Location - City	
Ē	9 U - L		1 Burial 2 Termation 3 Removal from State 1 Donation 5 Other (Specify) CUMBERLAND CREMATORY	15/09	CTIMBER	LAND, MD
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee / 22. Name and Address of Facility	HOME, E		
	70 = 4 0	3 (1	23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	CUMBI	ERLAND, M	21502 Approximate
	recipies and		shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death
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П	Examiner		Sequentially list conditions, b.			
	ed sit	Jiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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_	- CD 05		IF FEMALE:		Farmer.	
Box	eath certifi attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?		23d. Date of Month	delivery Day Year
o.	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown			
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<u></u>	ding Phys h. After this funeral dir	T:uc	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of linjury at Work?	28d. Describe h	ow injury occurred	
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Division of	or Attan after deat Diractor: in by the	Certification:	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tow	n, State)	r Rural Route Number,
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	, 7		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)		1 213,	7 2001
	nes		Robustiano Barrera, M.D. 500 Memorial Avenue,	Cumb	zerland,	MD 21502
	Sta Registr		31. Date filed (Month Pay Y2009 Server Signature Assistants Signature)			

09-01454 Harry Failor Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 06452

Physician Color Examines December Part Doc1 Failor, Fai	illy i alloi		For State	ato or maryia	Cert	ificate of	Death			Reg.	No.		
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The first of the second of the	Zillillo.	1	or condition resulting in death)	Due to (or as	a consequence	of):							3
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier O.C.M.E. OCME 29c. License number O.C.M.E. OCME February 20, 2009	/ital	m	examiner?		Inpatient 2	ER/Outpatie							her: Scene
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one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, eccur described and manner stated. 29d. Date signed (Month, Day, Year) February 20, 2009 30. Name and address of person who completed cause of death (Item 23a)	lospits 4 hours funera		20a Certifier	7.1	barat of market parel	edge, death oc	curred at the time	e, date and pl	ace, and	due to the cau	ise(s) and man	ner as s	stated.
290. Signature and the or certains O.C.M.E. OCME February 20, 2009 30. Name and address of person who completed cause of death (Item 23a)	o the lithin 2 or the l	dic	one) 2 Medical I	Examiner:On the bas and manne	sis of examination	and/or investi	gation, in my opi	nion, death o	ccurred a	t the time, date	and place; at		(-)
30. Name and address of person who completed cause of death (item 23a)	F 3 F 5	ž	29b. Signature and title of cer	rtifier		_				ME			
			Theoder	M. Ku	X TP.,	new					1		
Theodole M. Marg.	ŀ		 Name and address of per Theodore M. King, 		istant Medica	I Examiner	111 Penn	Street, Ba	altimore	e, MD 2120)1		
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	St	ate	31. Date filed (Month, Day, Ye	ear) 32	. Registrar's Sign	ature	1						

ORIGINAL

Frank Franklin Fowler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland /	Department of He	ealth and Me	ntal Hygiene

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		1- For State Registrar		Certific	cate of	Death			Reg. No.			
Physici	an/	1. Decedent's Name (First, Middl	e,Last)					2. Date of De		Voor	3. Time of Death	
Medical Exami	ner	Frank Frankli	in Fowler					February	13, 2009	Year)	0718 hrs	
F. goodle		4a. Facility Name (if not institutio	n, give street and number)		41	o. City, Town, or Lo	ocation of Deat			ounty of Deatl	i .	
		Union Hospital		-		Elkton			Ced	il		
Funeral	12	5. Social Security Number	6. Sex 7. Ag	e (In yrs. last bi	rthday)	If Under 1 Year	If Under 24Hr	s. 8. Date of I	Birth (MM/DD/	YYYY) 9. Bir	thplace (State or	
Director	10	214-11-4694	1 X M 2 F		28 Yrs.	Months Days	Hours Mir		6 10	Forei	^{gn} New Jersey	
		Usual Residence of Decedent	A W 2 1		20 113.			Dec.	6, 19	00	***************************************	
any ,	1	10a. State 10b. County		10c. City, Town	n or Locatio	n					10d. Inside City Limits	
*		Maryland Ce	ecil	F1	kton						1 Yes 2 X No	
ylanc one	Director	10e. Street and Number			K C O I I	10f. Zip Code			10a Citizon	of What Cou		
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th the Maryland 23a or 28a-f sho notified at once		119 Castlesto	ne Dr.			2192		USA				
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after iner	à		orced If Yes, Give Year or Dates:			Yes 2 X No					hite	
136 thin 72 hours a te. than "natural edical Examin	- pa	15. Decedent's Education (Spec	of Business/	Industry								
6 n 72 an "	et	Elementary/Secondary (0-12)	College (1-4 or	5+)		st of working life. D		· ·				
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. ked other than "naturint", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Completed	12			Carp	enter					ovement	
5-6 iled Hygi Hoth		17. Father's Name (First, Middle,	Last)			18	3.Mother's Nam	e (First, Middle	, Maiden Sur	rname)		
21215-0036 unld be filed within 7 Mental Hygiene. marked other than	Be	Phillip Fowle					Rita					
, MD 21215-003 and 2 should be filed within lealth and Mental Hygiene. ten 27 is marked other th traumatic event, the Med	ြ	19a. Informant's Name/Relations		7		Address (Street a					e, Zip Code)	
MD nd 2 sho alth and m 27 is	- 1	Kim Fowler/Si	ster			astlestor						
fmore, MD 2 Pages 1 and 2 shou nent of Health and 1 and 11 fittem 27 is 10 or other traumatic		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from St		of Disposit atory or othe	ion (Name of ceme er place)		Date -19-200		ation - City or	Town, State	
MO Paget ent o		4 Donation 5 Other Sp			Foard	Funeral	- 1			ng Sun	, Maryland	
Baltimore, permit, Pages I ar Department of Hee Important: If ite	1	21. Signature of Funeral S			22. Na	me and Address o	of Facility				,	
ii ii ii ii ii ii ii ii ii ii ii ii ii		1	1		K.	T. Foard	Funera	l Home	, P.A.	MD 2	1911	
Physician	7	Sa. Part I. Enter the disease, or	complications that caused	the death. Do r	not enter the	mode of dying, su	uch as cardiac	or respiratory a	rrest, shock,	or heart	Approximate Interval	
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Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 Unk	nown g Unknown		J _ Oth	er (Opcony)						
P.O. Box 68 st that the death certing and by the attending detached for use a		Part II. Other significant condit	ions contributing to deat	h but not resulti	ng in the ur	derlying cause giv	en in Part I.	23e. Dio	tobacco use	contribute to	the cause of death?	
PO es that to igned by be detac	<u>آھ</u>							1 Y	es 2 🗸 N	o 3 Pro	bably 4 Unknown	
ords, P w requires t is been sign should be o	ted							24a. Wa	is an	24b. Were a	utopsy findings available	
aw re	힐								opsy formed?		completion of cause of	
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tal Re(ian: The certificate	Be	25. Was case referred to medical					f Death (Check	only one)	•			
of Vital Records, ng Physician: The law requir Nfer this certificate has been si meral director, page 2 should t	2	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2 🗸 ER/0	Outpatient	3 DOA	ther Nursi	ing Home 5	Residence	e 6 Othe	er:	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		27. Manner of Death	28a. Date of Inju (Month, Day,) FOUND:	ury 28b	. Time of In	ury 28c. Injury	at Work?	28d. Describ Subject ha	e how injury			
Division tal or Attendi rs after death.	흹	1 Natural 5 Pend	"" ⁹ F-L 40 0000		UND: 30 hrs	1 Ye	s 2 🗸 No	Subject na	ingeu sen			
/isi	ig					, factory, office bui	ilding, etc.	28f. Location	(Street and	Number or R	ural Route Number, City	
Divis	Certification:	4 Homicide deter	mined (Specify) Jai	T				or Town Cecil Count	, State) y Detention	Center, Ell	kton , MD	
D To the Hospital within 24 hours To the Funeral		Office Codifice	nysiciap. To the best of m	v knowledge, de	eath occurre	ed at the time, date	e and place, an	d due to the ca	use(s) and m	nanner as sta	ted.	
To the Hos within 24 h To the Fuu completely	gi	one) 2 Medical Exam	miner:On the basis of exa	mination and/or	investigation	on, in my opinion, o	death occurred	at the time, da	te and place,	and due to the	ne cause(s)	
To To COIT	Medical	29b. Signature and title of certifie	and manner stated.			29c. License	number		29d. Dat	e signed (Mo	onth, Day, Year)	
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St Regis		31. Date filed (Month, Day, Year) FEB 19 2009		r's Signature	Med							
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State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** VIOLA LOUISE FLURRY 23 2009 9:05A M FEBRUARY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SOUTHERN MD HOSPITAL CLINTON PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Months Days 1 □ M 2 🖾 F 425-48-7229 81 NOV.24,1927 MISSISSIPPI Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at PR.GEORGE'S 1 ☐ Yes 2\(\)\(\)\(\) Director MD FORT WASHINGTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U. S. A. 1232 VAN BUREN DRIVE 20744 Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1
Yes 2

No 72 hours after 1 Tes 2 If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: WHITE ð 3 K Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 Is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) 12 DELI MANAGER GROCERY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SEMMIE BYRON GREENE OLLIE BELL RINKS ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDY FARREN/DAUGHTER 1090 CARSON_DR._HUNTINGTOWN, MD 20639 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) MARCH permit. Pages
Department of
Important: If It
any injury or o Burial 2 Cremation 3 Removal from State MD VETS.CEMETERY 3, 2009 CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1802 M006415635 WASHINGTON AVE., LA PLATA, MD 20646 Approximate Interval Between Opset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line MISA Immediate Cause (Final 10 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Equantizity list of utilians, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) The law requires that the death certificate be executed Examil Due to (or as a consequence of): physician s the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) ed by the Ö 9 Unknown 9 Unknown ۵. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 : autopsy 1 □ Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) WISO 201 31. Date filed (Month, Day, State Registrar

09-01467 Edward Fairbanks Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 06455

		- For State		Certific	cate of	Death			R	eg. No.	
Physicia edical Examir	ın/	egistrar 1. Decedent's Name (First, Middle,	Edward Har	rison Fairba		ИU			2. Date of Dea Month February	Day Year 19, 2009	3. Time of Death 1227 hrs
r.,		4a. Facility Name (if not institution, Easton Memorial Hospi		r)	41	c. City, Town Easton	, or Loca	tion of Deat		4c. County of I	
Funeral Director	1 0		. Sex 7. F	age (In yrs. last b	oirthday) Yrs.	If Under 1		Under 24Hr Hours Mi	n.	2/29/1958	B. Birthplace (State or Foreign Country) Maryland
11215-0036 It be filed within 72 hours after death with the Maryland Adental Higher death with the Maryland anarked other than "natural", or items 23a or 28a-f show any event, the Medical Examiner must be notified at once.	by Funeral Director	300] 11. Marital Status 1 Never Married 2 Mar	1 Yes rced If Yes, Give Year or Dates:	nt Ever in U.S. ss? 2 X No	13. Was	10f. Zip Coo Decedent of s, specify Cooperations of the cooperation	f Hispani uban, Me No sp cupation (ecify:	Specify Yes or Note Rican, etc.)	10g. Citizen of What 14. Race	USA American Indian, Black, etc.
D 21215-0036 should be filed within 72 hours after and Mental Hygiene. 7: is marked other than "natural", natic event, the Medical Examiner	-	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle,	College (1-4	College (1-4 or 5+)			d Sewe	NOT use re er Techn Mother's Nar	ician ne (First, Middle,	Maiden Surname)	ty Government
MD 2 nd 2 shou afth and M m 27 is r	To Be	19a. Informant's Name/Relationsh	rard Harrison F ip (Type, Print) rbanks / Sister	• dr	19b. Mailing		451 H	leritage I	r Rural Route No	ian Odella Le umber, City or Town, n Burnie, MD 20c. Location - C	State, Zip Code)
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and N Important: If item 27 is ninjury or other traumatic		1 X Burial 2 Cremation 4 Donation 5 Other Sp 21. Signature of Funeral Service	ecify:	State	22. N	r Memor lame and Ad	dress of	Facility	2/27/2009 Home, P.A.,		umbridge MD Cambridge, MD 21613
Physician Wedica .aminer 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):											Death
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	·							
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	sician/Medical	X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unit	23c. If yes, ou	tcome of pregna h at at time of death	ncy 2 Fe	perME ; etal death ther (Specif	3	Ectopic pre		23d. Date of Month	delivery Day Year
P.O. B es that the digned by the be detached	npleted by Phy	Part II. Other significant c/ndit			ulting in the	underlying c	ause give	en in Part I.	1	res 2 No 3 as an topsy rformed?	bute to the cause of death? Probably 4 Unknown Vere autopsy findings available into to completion of cause of leath? Yes 2 No
n of Vital I ling Physician: After this certif funeral director,	To Be C	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 X Natural 5 Pen	Hospital: 1 In In In In In In In In In In In In In		R/Outpatien 28b. Time of	t 3 DO	A Ot	hor:	eck only one) ursing Home 5 28d. Descril	Residence 6	Other: ed
Divisi pital or Att curs after d	Certifica	3 Suicide 6 Cou	rmined (Specify)	of Injury - At hon	death occ	urred at the t	ime date	and place.	or Town	n, State) ause(s) and manner	er or Rural Route Number, City
To the Hos within 24 h To the Fut completely	Medical	Check only 1 Certifying Pone) 2 Medical Exe	examination and ated.	my knowledge, death occurred at the time, date and place, and commination and/or investigation, in my opinion, death occurred at d. 29c. License number O.C.M.E.					ate and place, and c	ed (Month, Day, Year)	
	State		sistant Medical E		111 Penn	Street, B		re, MD 2	1201		
	TIGH!	MAG		The acres	1	Board					

ORIGINAL

09-01565	
William Fowlk	ces

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 06456 2009 1- For State Certificate of Death Registrar Rea. No Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day February 22, 2009 Medical Examiner 1549 hrs Kes iam 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death c. County of Death Peninsula Regional Medical Center Salisbury Wicomico 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or **Funeral** Days Hours Director Country) 5-08-191 *-25-*3384 1 XM 2 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No ccomac hincoteague Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10f. Zip Gode 10e. Street and Number 10g. Citizen of What Country? 23 1) rive Dea Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc 1 Never Married Armed Forces? Yes White f Yes. Give Year Yes 2 No specify: Specify: Widowed 4 Divorced 2 16a. Decedent's Usual Dccupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) item 27 is marked other than 'tranmatic event, the Medical MD 21215-0036 10 ent of Health and Mental Hygiene 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Foultes Adelia Be J. arroll Jones 19a. Informant's Name/Relationship (Type, Print) (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3-95 19b. Mailing Address 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State Baltlmore, crematory or other place) 1 X Burial 2 Cremation 3 lant: hincotegauz. VA Donation 5 Other Specify: Mechanics 21. Signature of Funeral Service Licenses hincoteague, UA Betts Salver Funeral Home, Inc mana Approximate Interva 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each lin Between Onset and Medical Atherosclerotic cardiovascular disease Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical X UNPENDED AMENDED 23a, 27, per ME, g889 3/6/09 TT attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknow Part II. Other significant conditions Completed by

The law requires that the death certificate be executed After this certificate has been s To the Hospital or Attending Physician: Certification: To within 24 hours after death.

To the Funeral Director:
completely filled in by the f

Be

Medical

	23c. If yes, outcome of pregnancy	230	. Date of delivery	
vn	1 Live birth 2 Fetal death 3 Ectopic pregnance 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	y	Month D	ay Year
•	contributing to death but not resulting in the underlying cause given in Part I.		-	he cause of death?
		24a. Was an autopsy performed?	prior to co death?	opsy findings available ompletion of cause of

25. Was case referred to medi	cal	26.Place of Death (Check only one)								
examiner?	Hos	pital: 1 Inpatient 2 V	ER/Outpatient 3	Basidana C Other						
1 Yes 2 No		Inpatient 2	ER/Outpatient 3	DOA	4 Nursir	ng Home 5 Residence 6 Other:				
27. Manner of Death		128a. Date of Injury	28b. Time of Injury	28c. Inju	ry at Work?	28d. Describe how injury occurred				
	ending vestigation	(Month, Day, Year)	(Month, Day, Year)							
3 Suicide 6 Co	ould not be	28e. Place of Injury - At he	ome, farm, street, factor	y, office t	ouilding, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
4 Homicide	etermined	(Specify)								
29a. Certifier 1 Certifying	Physician:	: To the best of my knowled	ge, death occurred at the	ne time, d	ate and place, and	due to the cause(s) and manner as stated.				

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 23, 2009

30. Name and address of person who completed cause of death (Item 23a)

24

Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Morph PB)

State Registra

32. Registrar's Signatur

			1 - For State Registrar	State of Mary		artment <i>rtificate</i>			nd Ment	al Hygie Reg	ene . No 20	09	06457
	Physici /Medio		1. Decedent's Name (First, Middle, La Dorothy Mildr	,					B.A.	ite of Death onth Puary	Day		3. Time of Death 8:32p M
	Examir		4a. Facility Name (If not institution, gi Frederick Mem		al	4b. City, To	own, or Lo		Death		4c. County Freder		
	Funeral Director		219-22-3772	1 □ M 2 1 F	yrs. last birthday) 80 Yrs.	If Under 1 Months		f Under 24 Hours	Min. (M	te of Birth fonth, Day, Y		Cour	place (State or Foreign ntry) cyland
	ne Maryland 8a-f show	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Freder		c. City, Town or Lo	У				40	022		0d. Inside City Limits 1 Yes 2 □ No
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercises out to notified at once.	eted by Funeral Director	10e. Street and Number 1215 Leafy Hollo 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 15. Decedent's E (Specify only highest gr	12. Was Decedent Ever Armed Forces? 1 □ Yes 2 1 No If Yes, Give Year or Dates:	16a, Dece	1 ☐ Yes 2[217 nt of Hisp y Cuban,	anic Origii Mexican, I Specify:	n? (Specify Yo	es or No- etc.)	Unit 14. Race Blac Specify	Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry	
2121	within 7 jiene. r than "n	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work DO NOT use omemak		ing most o	ii working		(Own H	lome
Maryland 2	ould be filed I Mental Hyg Iarked other Iatic event, I	To Be C	17. Father's Name (First, Middle, Last Adolf Eis					Ame	Name (First	bstrei	iden Surnam .t	e)	
Baltimore, Mar	Pages 1 and 2 shent of Health and It if item 27 is not or other traun		19a. Informant's Name/Relationship Deborah Trimble 20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3 □ 4□ Donation 5 □ Other (Speci	/ Daughter 2 Removal from State	1	Leafy esition (Name	Holle e of er place)	ow Ci	or Rural Roun rcle Date ebruar 3, 200	Mt. A	iry, M	aryla City or To	and 21771
Balti	permit. Departm Importa any Inju		21. Signature of Funerel Service Lice		2:	2. Name and	Address	of Facility	Stauf	fer Fu	meral	Home	s, P.A. nd 21771
4	Physician /Medical		23a. Part1. Enter the disease or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Bowel	perfo			such as ca	ardiac or resp	iratory arrest	,	1	Approximate Interval Between Onset and Death
8760,	Examiner	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Clostnic Due to (or as a co	dium nsequence of):	Dif	fic	ile					weels
O. Box 6	ath certific attending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 21 ☑ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	☐ Ectopic pre☐ Other (spec					23d. Date Mor	e of delive	ery Day Year
ords, P.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions		ailur c	nderlying cau	ise given i	in Part I.				ibute to th 3□ Prob	ne cause of death?
Vital Records,	: The law re cate has be page 2 sho	Completed							_	ta. Was an autopsy performe □Yes 2 🗓	d?	rior to coi leath?	psy findings available mpletion of cause of 2 No
Vita	ysician: The is certificate hidirector, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient	2 ☐ ER/Outpatie	nt 3□DOA	Othor:		f Death (Chec		e 6∏Othe	er (Snecif	iv)
Division of	or Attending Physiter death. Director: After this in by the funeral dii	Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigatio 6 Could not be determined	28a. Date of Injury (Month, Day, Yea n e 28e. Place of Injury -	te of Injury onth, Day, Year) 28b. Time of Injury Work? M 1 Yes 2 No 28d. Description of Injury At home, farm, street, factory, office					escribe how	injury occurre	ed	il Route Number,
7	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce		nysician: To the best of my miner: On the basis of exa and manner stated.									
Đ		Me	29b. Signature and title of certifier 30. Name and address of terson who TQUZI KIZVI 31. Date filed (Month, Day, Year) FEB 1		Rizvin	29c. 1	License no	umber		29d.	Date signed	(Month,	Day, Year) 49,2009
_	5		30. Name and address of herson who Fauzi Rizvi,	mp, 400	(Item 23a) (Type,	7+W	St	ree	+ , F(eder	rick		_
	Sta Registr	te ar	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature A.	park	1						

State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day 7, **Physician** 2009 Guillermina Gonzalez February 9:40 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 F 578-60-8808 85 20, 1923 Spain Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Wedles Examinar must be matthed at 1 ☐Yes 2▼ No Director Maryland Montgomery Kensington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4222 McCain Court 20895 USA Funeral death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 **X**No Maryland 21215-0036 1 □Yes 2 🙀 No Specify Specify White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benino Gonzalez Alejandra Suarez ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) i and 2 s Health a Encarnacion Garcia/Sister 4222 McCain Court, Kensington, MD 20895 Department of Health Important: If Item 27 any injury or other trong. Baltimore, Pages 1. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Feb. 12. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licenses 22. Name and Address of Eachith ins Funeral Home Inc. 500 University Blvd. W., Silver Spring. MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Insufficiency disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Chronic Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Unit to (or as a nunseculation of) Examiner be executed burial-trans Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IE EEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown à ۵. s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Diabetes Mellitus Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy certificate 1∐Yes 2X No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 🔼 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 24 hours after death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 📧 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Cino D56691 February 7, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ghousia Sultana, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) Registrar's Signature State 13 Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 0 9 06459 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 08, 2009 4:46 P M JOSE A. GOMEZ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 5. Social Security Number Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 6. Sex **Funeral** Months Days Hours 1 3 M 2 □ F Director 63 10/4/1945 230-57-1809 Canton El Bocan Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f shovevent, the Medical Expedient must be rectified at 1 AYes 2 □ No Director Maryland | Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20782 Salvadorian Funeral 5816 31st Place 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 X Never Married 2 ☐ Married altimore, Maryland 21215-0036 1♥Yes 2□No Specify: Salvadorian 2 Specify: Hispanic 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 6 Cleaner / Custodial Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jose' Adam Urutia Petronia Gomez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau 5816 31st. place Hyattsville, Maryland 20782 <u>Nulma Portillo / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) SaSan Rafael Oriente 2/20/2009 San Miguel, El Salvador 21. Signature of Funeral Service Lios see 22. Name and Address of Facility Pope Funeral Homes, P.A. M01085 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1 Ther the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** GI bleed /Medical Due to (or as a consequence of): Examiner Coggutopathi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ras a consequence Examine Attending Physician: The law requires that the death certificate be executed Sepsi3 (neutropenia sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical Gastric lymphoma 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No ours after death.

eral Director: After this certification in by the funeral director, I filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 ♣ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D68005 220 biadi JENNIFER OBIADI MD 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JENNI FER E. OBIADIMD 7600 CARROL AVENUE, TAKOMA PARK MD 31. Date filed (Month, Day, Year) State FEB 18 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 06460 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** A^M February Francis William Guns, Sr. 2009 0710 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Manor Healthcare Center Ceci1 Rising Sun 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year, DEC 3, 192 9. Birthplace (State or Foreign **Funeral** 80 Maryland Director 215-30-0709 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo E1kton Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 391 Maloney Road 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or health injury or other trainmans. Black, White, etc. 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: چ ک 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Carpentry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank W. Guns ဂ Anna Schneiders 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann G. Connor/Daughter 45 Enfield Road, Elkton, MD 21921 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Immaculate
Conception Cemetery 20a. Method of Disposition 20c. Location - City or Town, State February 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) 28, 2009 Cherry Hill, MD 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown β Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performe certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

29c, License number

ORIGINAL

29d. Date signed (Month, Dav. Year)

Registrar DHMH 17 Rev 1/2001

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within 24

State

29b. Signature and litle of certifier

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a)

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32. Regist/ar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Candace Felton Goebel P^{M} February 2009 2:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kline Hospice House Mount Airy Frederick 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) December 25, 1937 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 X F Days Hours Min 506-52-3043 71 Director Nabraska Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the marical Evant menust by rediffed Director . Monrovia Frederick 1 Yes 2X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 21770 United States 3816 Greenridge Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 1 Married Maryland 21215-0036 If Yes, Give Year or Dates: \$ 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Community Leader Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it and 2 should be fill Health and Mental H Be Royal Bradley Felton Ruth Riley 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3816 Greenridge Drive, Monrovia, Maryland 21770 Paul W. Goebel, Jr. / Husband item 27 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ō February 27, = 5 1 Burial 2 Cremation 3 Removal from State permit. Page Department important: if any injury or once. Smithsburg Crematory 2009 Smithsburg, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Services 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 3-4 Cerebrovascular Done 5 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter the High Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy for Month Day Year 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown NEYTOMO bras, s certificate has b 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 2 XNo 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No the 1 within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57107 February 25, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hiren N. Shah, M.D. 65-C Thomas Johnson Drive, Frederick, Maryland 21702 31. Date filed (Month, Day, Year) State Registrar A. park DHMH 17 Rev 1/2001

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Registrar DHMH 17 Rev 1/2001

State

Box 68760,

P.0.

32. Registrar's Signature

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	State of Maryland	Department of He	ealth and Mental	Hygiene

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7		4a. Facility Name (if not institution, give street and number)		c. City, Town, or Location of Lexington Park	Death		St. Mary's	74.0
		21265 Great Mills Road 5 Social Societis Number		If Under 1 Year If Under	24Hrs. 8. Date	of Birth(N	MM/DD/YYYY) 9.	Birthplace (State or
Funeral		5. Social Security Number		Months Days Hours	1.60		, 1955 Fo	Country)Wisconsin
Director		209-30-2770	Yrs.		Jul	y 22	, 1755	× 18 6 18 1
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vith the Maryland s 23a or 28a-f show a e notified at once.	a	21762 Card Road 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was	Decedent of Hispanic Orig	in? (Specify Yes	s or No-	14. Race - A White, e	merican Indian, Black,
ath w	Funeral	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No		es, specify Cuban, Mexican,	, Puerto Alcan, e	10.)		
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21215-0036 und be filed within 7 Mental Hygiene. marked other than ic event, the Medica	o Be	Robert Leo Greivell 19a. Informant's Name/Relationship (Type, Print)	9b. Mailing	Address (Street and Nun	nber or Rural Ro	ute Numb	er, City or Town,	State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera Hiportant: If item 7: is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ř	Adam D. Greivell/Son	13324	Fairfax Rd.	, Hager	stown	1, MD 2	1742
and 2 ealth tem 2 traum		20a. Method of Disposition 20b. Place	e of Dispos	ition (Name of cemetery,	Date		20c. Location - C	ity or Town, State
Baltimore, permit. Pages I at Department of He Important: If ite		1 Burial 2 X Cremation 3 Removal from State	shur	Crematory	2/23/20	09		ourg, MD
ti. Pa rtmen rtmen ortant	-	4 Donation 5 Other Specify: SILLEL 21. Signature of Funeral Service Licensee	22.1	Name and Address of Facilit	y Rest H	laven	Funeral	Chapel
Bal Bal Perm Depa Impe		CAA L C'	16	01 Pennsylvar	nia Ave.	, Ha	gerstown	t Approximate Interval
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do	not enter t	he mode of dying, such as o	cardiac or respira	atory arres	st, shock, or near	Between Onset and Death
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Box 687 e death certific the attending p		1 Yes 2 No 9 Unknown g Unknown		and the first state of the stat	Dort I 2	3e Did to	bacco use contri	bute to the cause of death?
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Division of Vital Records, tal or Attending Physician: The law requirers after death.		25. Was case referred to medical		Other	th (Check only o		Residence 6	Othor: Scane
Vita hysicia this ce	on and on a	1 Yes 2 No	R/Outpatie	III 3 DOA	Nursing Hon		how injury occurr	
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Di pital ours a	filled in by the rune	4 Homicide determined (Specify) Sidewalk		to the first data and	place, and due t	o the cau	se(s) and manner	r as stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and			, death occ /or investi	curred at the time, date and gation, in my opinion, death	occurred at the	time, date	and place, and	due to the cause(s)
To th within	dwoo	and mariner stated.		29c. License numb			29d. Date sign	ned (Month, Day, Year)
	2	29b. Signature and title of certifier		O.C.M.E.			February 1	8, 2009
		Meller Brassl 4, 110	23a)					
2		30. Name and address of person who completed cause of death (Item 2 Melissa Brassell, MD Assistant Medical Examine	er 111	Penn Street, Baltim	ore, MD 212	:01		
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State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 17, 2:45 p. February 2009 /Medical Stuart Edgar HESS 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Broadmore Assisted Living Washington

9. Birthplace (State or Foreign Country) Hagerstown 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Und **Funeral** 1 X M 2 □ F Days Hours Min. Months 76 **Director** April 11, 1932 217-28-6220 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified Director 1 ☐ Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral 1175 Professional Court 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1XYes 2 □ No 1 Never Married 2 Married 0 If Yes, Give 1 □Yes 2**X** No Specify. þ 3 X Widowed 4 ☐ Divorced Specify: Year or Dates: 1952-54 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Manufacturing Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ John S. Hess Bertie V. Whittington 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Diane Whittington - Daughter 317 Kingswood Terrace, Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 2/20/09 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** (OW disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, # Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? rs after deau...
ral Director. After this cer..... 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0055994 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 176-HO Medical Campus Rd, Hagerstown Higginbotham Dr. Lisa 11.110 31. Date filed (Month, Day, Year) State Registrar

1 - For State Registrar

			1 - For State Registrar	Otate of W	arytaria / L		cate of L		Mentarri	Reg. N	200	9	06466
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4	/Medic		Patricia Ann H						FEBRU	ARY	18 200		1'56A M
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	ath w	- Ca	35 North Locus				21741				USA		
	item Item	Funeral Director	11. Marital Status	12. Was Decedent	?	13. Was E	ecedent of Hi specify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or I rto Rican, etc.)	No-	14. Race - A Black, V		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "naturel", or Itema 23a or 28a-f show other traumatic event, the Mudical Exertings is and be recilled at	by F	1 ☐ Never Married 2 ☐ Marri 3 ※ Widowed 4 ☐ Divorced	ed 1 □ Yes 2 💢 If Yes, Give Year or Dates:	NO	1 □ Y	es 2 No	Specify:			Specify:	Whit	·e
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			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cause only one cause on each l	d the death. Do n ine.	ot enter the	mode of dying	g, such as cardia	c or respiratory	arrest,		Ir	pproximate nterval Between
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	uted I	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	nie CA		AMORA	THU					4 GARS
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Вох	eath ce atlendii for use	an/i	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	of pregnancy 2 Fetal death	3 □Ector	ic pregnancy				23d. Date of Month	delivery Da	av Year
	at the dea by the a stached f	Physician/i	1 ☐ Yes 2 ₹ No 9 ☐ Unknown	4 □ Pregnant a 9 □ Unknown	t time of death	5 🗌 Othe	r (specify)				MOUIT	0.	ay real
P.0	that the ed by detac		Part II. Other significant condition	s contributing to death t	out not resulting in	the underly	no cause oive	n in Part I.	23e. Dio	tobacco	use contribute	e to the	cause of death?
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0	ding Ph h. Afler th funeral		27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year) 28b. T	ime of	28c. Injury Work	at ?	28d. Describe	how inju	iry occurred		
sio	Attending r death. actor: Afler by the fune	cati	2 Accident investig	ation		М		res 2 □No					
Division	Ital or Attenres after deatral Director:	Certification:	4 Homicide determin	286. Place of in	ury - At home, far ic. (Specify)	m, street, fa	ctory, office			(Street a. own, Stat	nd Number or e)	' Rural A	Route Number,
	To the Hospital or a within 24 hours after To the Funeral Direction completely filled in b	Medical	29a. Certifier 1 critifying (Check only 2 Medical E	Physician: To the best xaminer: On the basis o and manner st	it examination and	death occu Vor investiga	rred at the tim ation, in my op	e, date and place sinion, death occ	e, and due to th urred at the time	e cause(s e, date an	and manner d place, and	as state	ed. e cause(s)
_	To t To t	Σ	29b. Signature and title of certifier	NA.)		29c. License			29d. Da	ate signed (Mo	onth, Da	y, Year)
			1	191	ノ 			2895		FEB	RUARY	. 18	, 2009
			30. Name and address of person w		leath (Item 23a) (Type, Print)	1500 I	Pennsylvar	nia Avenue	9			
74		. 5	PAULINE DALLY 31 Date filed (Month Day Year)	RICHARDS	ar's Signature		Hagers	stown, MD	21742				
	Sta Registr		31. Date filed (Month, Day, Year)	9 2009	ars signature	do	de la						
DH	MH 17 Rev 1/20	001				7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Division of Vital Records, P.O. Box 68760,

			State of M				Health and			-	00107	
		1 - For AMEND#30 Per PHY State Registrar 2/17/09 AAC				rtificate of		wentai ny	Reg. No.	C 0 0 J	0646/	
		1. Decedent's Name (First, Middle, Last) Certificate of Death						Date of Death 3. Time of Death				
Physicia /Medic	cal	Edith Crisp Howard				Februa			y 6,	200 ^{Year}	11:20 PM	
Examin		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of Death			
		Larkin Chase Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)				Bowie			Prince George's			
Funeral Director		451-03-8818	Sex 1 □ M 2XXF 7. A		10 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		a <i>y, Year)</i>	9. Birt Co Te	hplace (State or Foreign untry) XAS	
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits	
Mary a-f sh	tor	Maryland Prince George's Lanham									1 □Yes 💥 No	
th the	Director					10f. Zip Code	10f. Zip Code			zen of What Co	untry?	
ath wi		7312 Riverdale Road				20706			USA			
er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forceş? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No			S. 13.	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.			
Is aft	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 9 Year or Dates:				1 □Yes 2 No Specify:				Specify: White		
2 hou	Completed	15. Decedent's Education 16a. Decedential 16a. Decedentia				dent's Usual Occupation			16b. Kind of Business/Ir			
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t be fill be fill be ed ot	Be	17. Father's Name (First, Middle, Last)					,	Mother's Name (First, Middle, Maiden Surname)				
should nd Me mark martic	မ	• • • • • • • • • • • • • • • • • • • •						Patty Carr Rural Route Number, City or Town, State, Zip Code)				
nd 2 saith ar alth ar 27 is r trau		Janice J. Howard		r	1		e Road L				ip code)	
s 1 au of Hea item		20a. Method of Disposition		20b. P		sition (Name of natory or other place		Date		cation - City or	Town, State	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If the 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Madical Eventing and Injury or other traumatic events.		1 M Burial 2 □ Cremation 3 □ Removal from State										
permit. Depart Import any Inj once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral 1							ral Home			
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	Examiner	shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death		
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Hospital or 24 hours afte Funeral Dir tely filled in I		Only of Town, State)										
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical	29a. Certifier (Check only one) **To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
To the within 2 To the comple	Σ	29b. Signature and title of certifier	29c. Licens				29d. Date signed (Month, Day, Year)					
ah	D34525							2/9/2009				
3400		30. Name and address of person who Sankineni J. Rao Aroor Rao M.D.	·			•	re 208 Bo	owie. Mr	207	16		
Sta		31. Date filed (Month, Day, Year)		trar's Signa	ture.	a. W. J						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year George Edward Humphries 2:30 P 2009 BRUAR 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Anne Arundel Glen Burnie 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 ☑ M 2 ☐ F Days Hours 85 490-32-4057 Mar. 10, 1923 Missouri Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD Anne Arundel Severna Park 1 ☐ Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 393 Stonehouse Drive 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No WW Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. WWII 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Electrical Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Humphries Veda Reaves 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Gruen/ Daughter 510 Mystic Lane Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 10, 20c. Location - City or Town, State Feb. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. Baltimore, MD 2009 Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Sewide License 23 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoo, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Physician /Medical Examiner

Physician

/Medical

Examiner

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wydical Evan Louis be notified 34 once.

Maryland 21215-0036

Baltimore,

Examiner Physician/Medical

use as the burial-transi and physician signed by the attending be detached for use as

P.O. Box Vital Records, Division of

68760.

hours To the Funeral completely 24

Medical Registrar

29a. Certifier

29b. Signature and title of certifier

Completed by After this certificate has funeral director, page 2 s Be မ Certification: Hospital or Attending neral Director; A

FEB 1 2 2009

and manner stated

D0061219

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

HOSPITAL GLENBURNIE MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SINGH HRORA BWMC

31. Date filed (Month, Day, Year)

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غوط	by the a	Physic	1 □Yes 2 □No 9 □ Unknown	9 Unknov	nt at time of de vn	atn 5∟	Other (specify) _					
Division: The law requires that the death certif	signed I	þ	Part II. Other significant conditions of	contributing to dea	th but not resul	ting in the ur	nderlying cause giv	en in Part I.	23e. Did t	V	oute to the cause of d 3 ☐ Probably 4 ☐ l	
aw requires 1	as beer 2 shoul	Completed							24a. Was		ere autopsy findings ior to completion of c	available
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VIIC	certifi rector,	Be	25. Was case referred to medical examiner?	Hospital: , ℷ✓.	_		. all DOA Oth	or.	ath (Check only o			
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5 4	er this teral di	-1	27. Manner of Death	28a. Date of	Injury :	28b. Time of	200, Inju	42 ~ ·		mon injury documen	u	
SICIL OF	eath. tor: After this the funeral di	-1	1 Natural 5 ☐ Pending 2 Accident investigation	28a. Date of (Month)	Day, Year)	Injury	M 1 E	k? lYes 2□No				
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09-01287 Alfred Lee Hoffman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 06471

04 200 / / / / / / / / / / / / / / / / / /		1- For Sta				J		Certi	ficate of	Death					Reg. N	0.			
Physicia		Registrar 1. Deced	dent's Name (First, Middle,Last)								Date of D	Day	Yea	r	3. Time of Death 2121 hrs				
dical Examir	ner	Al	fred		Lee	H	offi	man						Februai	ry 12, 2	2009	f Doo		
15 100			ty Name (Mary's I			e street and	number)		41	b. City, Tow Leonard		cation of I				4c. County St. Mary	's		
Funeral		5. Social	Security	Number	6. Se	×	7. Ag	e (In yrs. las	t birthday)	If Under 1		If Under		8. Date of	f Birth(M	M/DD/YYYY	Fore	irthplace (State or ign	
Director			3 56			M 2	F	57	Yrs.	Months	Days	Hours	Min.	May	18,	, 195	0	wash.	, DC
21215-0036 Mult be filed within 72 hours after death with the Maryland henral Hygiens and the Maryland henral Hygiens of the marked other than "natural", or items 23a or 28a-f show any nevent, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10a. Star MD 10e. Str 260 11. Mart 1	eet and No. 30 1 tal Status Alever Mari Vidowed accedent's beentary/Se and 12 mer's Nam Ered	induction (First, My e	Married Married Married Married (Specify of 00-12) Middle, Las	Armed 1 Yes, Give or Dates: nly highest	Decedentide Forces's 2s Year grade cor	M Ever in U.S? No	16a. Deceden during m	1 CSV 1 10f. Zip Co 2 (s Decedent es, specify (Yes 2 t's Usual Ocost of workin ect 1	of Hispa Cuban, I No ccupation ng life. I	9 anic Origin Mexican, I specify: on (Give ki DO NOT u ager 8.Mother's	nd of we see retire	ork done ed)	n No-	14. Race White Specify: b. Kind of B	US e - Americe, etc. Will usines	erican Indian, Black	No
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Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within logenthent of Health and Mental Hygiene. In them 17 is marked other it Important: If item 27 is marked other the injury or other traumatic event, the Med		1 X	Donation	Cre	mation 3 her Specifi ervice Lice	Remo	val from S	Tri - M000	1112	her place) Gardo Name and A	ens	of Facility	BRI	SCO	09 E-TC	Wald NIC	or FUN	NERAL HO	
The same of the same of		GUN	nver	ЩC	PIU	XXX	- /C	MUC.	Do not enter	94 O]	dying,	wasn such as ca	ardiac or	respirato	ry arrest	, shock, or h	eart	Approximate Between Ons	Interval
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and manachastic filled in the funeral director mase 2 should be detached for use as the burial - transit	Physician/Medical	IF FEI 23b. W	MALE: as decede ast 12 mor	ent pregnanths?	ant in the	23c. lt	yes, outo	at time of de	2 F	etal death Other (Spec		Ectopi	c pregna	ancy		23d. Date Month		•	ear
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To the within 2	comple	one)	2 Signature			ner:On the and ma	basis of e anner stat	examination ed.	and/or investig			se numbe		at the tith	e, uate a	29d. Date	signed	to the cause(s) (Month, Day, Year)	
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Reg		ar		T	D A	2000	por		- 1/							UUIVIE			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Februar Day Year Edward Everett Hess **Physician** 15 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hagerstown Washington County Hospital Washington 8. Date of Birth (Month, Day, Year) Aug 9, 1921 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Maryland 1**X** M 2□ F Months Days Hours 87 215-14-1311 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State show ral", or items 23a or 28a-f shov Examir ar must be notified at 1 Yes 2 □ No Hagerstown Director Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 21742 19800 Tranquility Circle Room 102 USA Funeral Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married white 1 ☐Yes 2 No Specify Specify. <u>م</u> 3 X Widowed 4 ☐ Divorced "natural" tal Hygiene.

Jother than "natura event, It e Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked c Edna Viola Harner Ralph Everett Hess ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 18309 Woodside Dr, Hagerstown, MD 21740 Terrie A. Hendricks, daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Lutheran Cem 02/19/2009 Taneytown, MD 4 Donation 5 DOther (Specify) Myers-Durboraw Funeral Home 22. Name and Address of Facility 21. Six ature of Funeral Service Licensee 136 E Baltimore St, Taneytown, MD 21787 mile 23a. Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to ras a consequence of): **Physician** heart /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 1 Live birth 2 Fetal dead 3 Ectopic pregnancy Day 5 Other (specify) 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ failure, bronchin's 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 328 autopsy s certificate ha irector, page 2 performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 4. ☐ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ieral Director: / after death 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af **To the Funeral D**completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

WJZ 4

Baltimore, Maryland 21215-0036

State

Registrar

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Hagerstown,

1138 Opal Ct.

02/16/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G890 4/17/09 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2009 06473 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 14, 2009 Eva Hope Heltebridle **Physician** 1:13 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Lorien Nursing & Rehabilitation Taneytown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Security Number **Funeral** Days 1 □ M 2 F 95 Mar 15, 1913 Pennsylvania Director Usual Residence of Decedent of 2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifiled at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Taneytown Maryland Carroll Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21787 435 East Baltimore Street USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white δ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic evonce. Laura C. Stremmel John W. McCleaf 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 431 E. Baltimore St, Taneytown, MD 21787 Larry A. Heltebridle, son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 02/18/2009 Grace UCC Cemetery Taneytown, MD 22. Name and Address of Facility Myers-Durboraw Funeral 136 E Baltimore St, Taneytown, MD 21787 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of during, such as cardiac or respiratory arrost shock or heart failure. List only one cause an ach line. Immediate Cause (Final disease or condition resulting in death) Physician 24 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any to almost immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, the aftending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) n signed by the a P.0. 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ No 3 Probably 4 Unknown V 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perforn 1 ☐ Yes No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one Be Other: Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation atural 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier WJL 10 Name and address of person, who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Jack

DHMH 17 Rev 1/2001

Registrar

			1 → For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of rtificate o	Health a f Death	nd Mental Hy	/gieng 0 0 9	06474	
I	Physici /Medic		1. Decedent's Name (First, Middle, Last) Helen V. Hoffmann					2. Date of D Month 02-17-		3. Time of Death 1945 P M	
	Examir		4a. Facility Name (If not institution, give 6 Hopewell Road			Havre	de Grac	.e	4c. County of Dea Harford	th	
	Funeral Director		5. Social Security Number 6. Security Number 134-14-0435 Usual Residence of Decedent	וא סרער	(In yrs. last birthday)	If Under 1 Year Months Day		4 Hrs. 8. Date of B (Month, D) 09 / 08 /	irth ay, Year) 9. Bir Co 1923 Neu	thplace (State or Foreign buntry) YOTR	
	Maryland	tor	10a. State 10b. County Maryland Harford		10c. City, Town or Lo Havre de		.,			10d. Inside City Limits 1 ☐ Yes 2 No	
	h with the 23a or 28a st be noti	al Direc	10e. Street and Number 6 Hopewell Road			10f. Zip Code 2107		(10g. Citizen of What Co InitedStates		
980	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or Items 23a or 28a-f show ther then "neturel", or Items 23a or 28a-f show out, the Modical Exercitives.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Co	uban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	Black, Whit		
21215-0036	filed within 72 ho Hygiene. other then "neturent, IT e Madical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne durina most	of working	16b. Kind of Business Clerical	/Industry	
Maryland	should be file ind Mental Hy s marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) Sebastian Schroehe				Vales	's Name (First, Middle ka Klimpel	2		
	of Health a fitem 27 la		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	executor)	135 K 20b. Place of Dispo	ent Shor	e Drive	c, Carmel,	New York 10	7512 Town, State	
20a. Method of Disposition 1 Removal from State 1 Date 20c. Location - Circle and Address of Facility 20a. Method of Disposition 1 Removal from State 1 Date 20c. Location - Circle and Address of Facility 22c. Name and											
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8760,	sate be executed physician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last).	consequence of):						
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Records,	The law re ate has bee page 2 sho	Completed	- Essentia	H	perte	nsión	,	perl		utopsy findings available completion of cause of	
f Vital	ding Physicien: The h. Atter this certificate ha funeral director, page	To Be (25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatien	t 2 ☐ ER/Outpatie	nt 3□ DOA		of Death (Check only	one)	c(fy)	
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	the Hosp in 24 hou the Funer ipletely fill	Medical	29a. Certifier 1 Dertifying Physics (Check only one) 2 Medical Exami	sicien: To the best of ner: On the basis of and manner state	examination and/or in	vestigation, in m	y opinion, death	place, and due to the n occurred at the time	e cause(s) and manner as , date and place, and due	to the cause(s)	
	To To con	2	29b. Signature and title of certifier	emes	Lno	29c. Lice	inse number	3	29d. Date signed (Mont	n, Day, Year)	
_			30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type,	Print)	Lan	/ St. >	berded.	Manylan	
. .c.	Sta Regist		31. Date filed (Month, Day, Year)	32. Registra	's Signature	haves			7100.	,	

			roi	-	Department of H		Mental Hy	giene	0 06175
			_ State Registrar		Certificate of I	Death		Reg. No. ZUU	9 00412
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)	11			Date of Dea Month	Day Year	
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	Examin	er	la. Facility Name (If not institution, give street and nu 122 West Center	Street	46. Clty, lown, of	Location of Death	e ~	4c. County of De	o th
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birt	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h 9. B	irthplace (State or Foreign
	Director		212-24-2108 ¹ ⊠ ^{M 2□} F	81	Yrs. Months Days	Hours Min.	(Month, Day March 1	0, 1927 Ma	Country) ryland
	pu 💃		Jsual Residence of Decedent	10c. City, Town					
	aryla shov	'n	Oa. State 10b. County						10d. Inside City Limits 1 X Yes 2 □ No
	the M	Director	MD Garrett Oe. Street and Number	Kitzmi	10f. Zip Code			10g. Citizen of What C	
	with		122 W. Center Street		21538			United Sta	
	ms 2%	Funeral	11 Marital Status 12. Was Dec	edent Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S			nerican Indian,
စ္	or ite		Armed Formation 1 □ Never Married 2 ☑ Married 1 ☑ Yes If Yes, G	2 No Korea	1 ☐ Yes, specify Cuba	an, Mexican, Puerto Specify:	o Rican, etc.)		ite, etc.
21215-0036	ours ral",	d by	3 ☐ Widowed 4 ☐ Divorced Year or E	Dates: & WWII	To les Zigino	эреспу.			hite
5-	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	during most of worl	king	16b. Kind of Busines	s/Industry
12	withir ene. t han	duc	Elementary/Secondary (0-12) College (Roofer & Pa	,		Construc	tion
9	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the modical Eventhar must be notified at	Be Co	17. Father's Name (First, Middle, Last)		ROUTEL & LA		ne (First, Middle,	Maiden Surname)	CIOII
<u>la</u>	lid be fental rked rked fic ev	To B	Henry Harrison Hard	esty		Anna	Grace	Upho1e	
Maryland	should and Mer s marke sumatic		19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Street	and Number or Ru	ral Route Numbe	er, City or Town, State,	Zip Code)
	and 2 ealth s n 27 is		Louise Hardesty, Wife		22 W. Cente		, Kitzmi		21538
ore	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it as in or other traumatic event, it as in or other traumatic event, it as in or other traumatic event, it as in or other traumatic event, it as in or other traumatic event, it as in or other traumatic event, it as in or other traumatic event, it as in or other traumatic event, it as in or other events in or other events.		20a. Method of Disposition 1 □ Burial 2 XXCremation 3 □ Removal from	20b. Place of cemeter	Disposition (Name of y, crematory or other place	e)	Date	20c. Location - City of	r Town, State
Ë	. Pages tment of tant: If ite jury or o		4 □ Donation 5 □ Other (Specify)	Cumber	land Cremat			Cumberland	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	T. C	David A. 710 Chur	ss of Facility Burdock ch St., I	Funeral Kitzmill	Home, P.A er, MD 21	538
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do r					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	LSCU D					Onset and Death
	/Medical		resulting in death)	(or as a consequence of	of):				Jones
	Examiner	L	Sequentially list conditions, b.						
	ted sit	nine	cause. Enter Underlying	(or as a consequence of	of):				
	execu n and al-trar	Examiner	Cause (Disease or injury that initiated events c	(or as a consequence of	of):				
8760,	ficate be executed physician and s the burial-transit	dical	d.						
68	tifical ng phy as th	ledi							
Box	leath certific attending p for use as	an/N	23b. was decedent pregnant	tcome of pregnancy birth 2 Fetal death	3 Ectopic pregnanc	v		23d. Date of d	
o :	e dea the at hed fo	Physician/Me		nant at time of death	5 Other (specify)	,		Month	Day Year
<u>о</u> .	hat ti	Ph	Part II. Other significant conditions contributing to o	leath but not resulting in	the underlying cause give	en in Part I	23e. Did to	bacco use contribute	to the cause of death?
ds,	uires that the de signed by the a d be detached f	d by	(OPD	g	. and annually, mg cause give		1 □ Y		Probably 4 Unknown
CO	w requir been s should	Completed		_			24a. Was a	of called a females	autopsy findings available
Be	he law e has	дшс					autop perfor	sy prior to med2 death?	completion of cause of
Vital Records,	slcian: The certificate h rector, page	Be C	25. Was case referred to medical			26. Place of Dea			s 2 No
>	Physici this cer al direc		exammer? 1 Yes 2 No Hospital:	Inpatient 2 ER/Out	tpatient 3 DOA Oth	or:		lence 6 Other (Sp	ecify)
0	ding Ph h. After th funeral	L:uo	27. Manner of Death 28a. Date 1 Natural 5 Pending (Mor	of Injury 28b. T	rime of 28c. Injur	y at k?	28d. Describe h	ow injury occurred	
sio	tendi eath. tor: A	cati	2 Accident investigation			Yes 2□No			
Division of	al or Attend s after death Il Director: A	Certification: To	determined 200, Flace	e of Injury - At home, far ling, etc. <i>(Specify)</i>	rm, street, factory, office		28f. Location (S City or Tow	treet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Euhoraal Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the and man						
	To the within To the comple	Me	29b. Signature and title of certifier		29c. Licens	e number	:	29d. Date signed (Mor	nth, Day, Year)
		VA	* Kirch Dann	1 mids	Lepo H	1615	7	02/16	5/2005
	d	4	30. Name and address of person who completed cau	se of death (Item 23a) ((Type, Print)	Wolt	AE	ros Diag	Kland MD
	Sta	_		Registrar's Signature	ball				21450
	Registr	ar	FEB 17 2009	Eneva B.	gar		<u>-</u>		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Antoni Hruzd February 12, 2009 10:25A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 101 Tarragon Lane Edgewater Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 3, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days Hours 220-30-4092 91 1917 Poland Director Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 27 is marked other than "natural" or items 23a or 28a-f show traumatic event, the Modeal Examinator state by notified at 1 □Yes 2 No Director Anne Arundel Maryland Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic event. 21037 USA 101 Tarragon Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kazimierz Hruzd Stanislawa Kot ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Tarragon Lane Edgewater, Maryland 21037 Emilia Hruzd/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 2/14/2009 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service Licenses 22. Name and Address of Facility George T. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Maryland 21037 23a. Par 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Staph Physician Sepsis 1 month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 4 Pregnant at time of death Month Year Day 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 02/438 February 12, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Michael J. LaPenta, M.D. 445 Defense Hwy. Annapolis, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

James Allen Harley	1	- For State	Sta	te of N	Maryland		rtment of tificate of			d Men	tal Hy		Reg. No.	2	00	9	0647
Physician/ Medical Examine	1	1. Decedent's Nam JAMES ALI		,								2. Date of De Month February	eath		1	3. Time o 1924	
1	4	4a. Facility Name (i Prince Geor		_)		4b. City, To Cheve		_ocation o	of Death			c. County of Prince G		3	
Funeral	1	5. Social Security N	lumber 6	. Sex	7. Ag		ast birthday)	If Under			er 24Hrs.		•	/DD/YYYY)	Foreign		
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21 be fill rked ent,	3	17. Father's Name JAMES B. H.	ARLEY, JR]	MARGA	RET L	. SWANN	HARL	EY			
MD 21 d 2 should th and Me n 27 is man aumatic ev	2	19a. Informant's Na			Print)			-				ural Route N			, State,	Zip Code))
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Baltimore, ME peniit: Pages land 2 s Depariment of Health at Important: If item 27 injury or other traum:		21 Sgnature of Fu LYDIA C. TI			N M0058	3	**************************************	KNICK 9 LIVI	FUNE NGSI	RAT. H	ŎME, AD, I	P.A. NDIAN H	EAD, I	MARYLAN	ID 2	0640	
Physician /Medical	1	23a. Part I. Enter the failure. List on	ne disease, or c ily one cause o	n each Iir	ne.		. Do not enter t	he mode of	dying,	such as c	cardiac or	respiratory	arrest, sh	ock, or hea	rt	Betwee	en Onset and
kaminer		Immediate Cause or condition resulti			tgun Woun				_	-		Na.			-		Death
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uted Ind Iransit		events resulting in		Due t	to (or as a cons	sequence o	f):				-						
(0, e be executed ysician and burial - transit		UNPENDED	1	AM	IENDED												
6876(certificate nding physes as the b	2	IF FEMALE: 23b. Was decedent			c. If yes, outco	ome of preg		etal death	3	Ectopi	c pregna	ncy	23	3d. Date of one Month	delivery Da	ay	Year
tal Records, P.O. Box 68766 cian: The law requires that the death certificate certificate has been signed by the attending phy ector, page 2 should be detached for use as the tBe Compuleted by Physician/Me	310	past 12 months		lown g	Pregnant a	at time of de	eath 5 O	ther (Speci	fy) _								
O. Box (and the death or deby the attencetached for use		Part II. Other sign				th but not r	esulting in the	underlying	cause g	iven in P	art I.	23e. Di	d tobacco	o use contrib	oute to t	ne cause	of death?
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Division ral or Attendii rs after death. ral Director: A led in by the f.		Natural Accident	5 Pendii	ng igation	Feb 11, 200	9	FOUND: 1729 hrs			/es 2 ✓	No				D	al Davida	Number City
Division o pspiral or Attending hours after death. meral Director: Aft y filled in by the func Certification:		3 Suicide 4 Homicide	6 Could determ	not be nined	(Specify) Si		ome, farm, stre nily	et, ractory,	onice b	unang, e	ic.	or Towr 2385 Davis	, State) Road,	Waldorf, N	1D	ai Roule	Number, City
Ho Fun Fun		29a. Certifier (Check only one) 2		iner:On	Γο the best of r	my knowled	lge, death occu)
To the within To the comple	<u> </u>	29b. Signature and		and	manner stated	1.				e number				. Date signe			
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\n_	T	30. Name and add	ress of person v /incenti, MD		leted cause of		minor 11	1 Penn S	Street	Baltim	ore M	D 21201					
State	e	31. Date filed (Mor	th. Dav.Year)	07.12	32. Legistr		urly fac	New York	-,,,	- Damin	.510, 141.			-			
Registra			EB 13	2009	Lever	un,	M. 19"	. —									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 06478 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Percy Iames William /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Morial Birthplace Country) Date of Birth (Month, Day, Year) (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min. Days 1 ☑ M 2 □ F Months Hours Director 84 07/08/1924 Maryland 216-18-1769 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm May Ical Examiner must be notified at 1 XYes 2 No Director MD Cumberland Allegany 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? USA 21502 948 Bedford Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No 1942 – If Yes, Give Year or Dates: 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White ş 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical 12 Physician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Iames Mary Virginia Iliff Percy Americus ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Linden Street, Cumberland, MD item 27 r other to William P. Iames, II / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter
any Injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 102/17/2009 Zion Memorial Park Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neu mon Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?
Yes 2 No death? certificate 2 □ No 1 ☐ Yes 1 🗆 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760, i 24 hours after death. e Funeral Director: Af letely filled in by the fur completely within 2 the 0

> m &s State

Sunil Gupta, 31. Date filed (Lon Registrar

29b. Signature and title of certifier

29a. Certifier

(Check only one)

> M.D., 625 Kent Avenue, Cumberland, MD 32. Registrar's Signature Barton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

20033280

29d. Date signed (Month, Day, Year)

200

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Physician 21:40 M Т. Irby 2-9-09 Melvin /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Adventist Takoma Park Montgomery

9. Birthplace (State or Foreign Country) Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Months Hours 1**X** M 2 □ F 247-82-2309 59 8/21/1949 Director South Carolina Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, its Medical Examine must be notified at 1 FYes 2 □ No Director Brandywine Maryland Prince George 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with USA 20613 15805 Brandywine Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. ò 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Supervisor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental McKinley Irby Μ. Warna John 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 15805 Brandywine Rd, Brandywine MD 20613
ace of Disposition (Name of Date 20c. Location - City or Town, State Warna Irby/ Mother other Department of Heali Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Harmony Memorial 2/16/09 Landover, Maryland 21. Si nalui - Lugeral Servio Licensee 22. Name and Address of Facility tu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Aquasco, MD 20608 shock, or heart failure. List only one cause on each line Embolism Immediate Cause (Final disease or condition resulting in death) Ylmona **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician sthe burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been signed 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No 24a. Was an autonsy certificate ha perform 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 2ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending 1 ☐Yes 2 ☐ No investigation ours after death. 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 > certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hound To the Fune completely fi Medical 29a. Certifier (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Are Takons JAMES 7600 20912 (h7 001 31. Date filed (Month, Day, 1 Year) 7 2009 32. Régistrar's Signature State Registrar

	Please	Type or Prin	t in Bla	ack In	delible Ink	Ensu	ıre A	II Copies /	Are Leg	gible.	
For		State of Ma	ryland	/ Depa	artment of H	lealth a	and N	Mental Hyg	iene		
1 - State Registrar			•	Cei	rtificate of	Death		Re	eg. No 🔿 🕜	200	00100
1. Decedent's Name	e (First, Middle, La	ast)						2. Date of Deat	h Zt	109	3: Time of Death
Co	orgo Fo	lward Ibex	. Sr.					Februar	Day 1.7	Year 2009	4:22 p M
		ve street and number)	, DI.		4b. City. Town, o	r Location o	of Death	repruar		nfy of Death	
	unas Lar				Westm					rroll	
5. Social Security N			(In yrs. las	t birthdav)	If Under 1 Year			8. Date of Birth			place (State or Foreign
215-24-21 Usual Residence of	.57	NZ M 2□F	81	Yrs.	Months Days	Hours	Min.	(Month, Day, Oct 27,	^{Year)} 1927	Con	/land
10a. State	10b. County		10c. City,	Town or Lo	cation		_			Т	10d. Inside City Limits
_											1 ∐Yes 21⊠No
Maryland	Carrol1		We	estmi	nster			14/	Do Citizon o	6 14/h a 4 Ca	
10e. Street and Nun					10f. Zip Code			"	0g. Citizen o		intry?
2616 Yc	oungs Lar				2119					SA	
11. Marital Status		12. Was Decedent E Armed Forces?	_	13.1	Was Decedent of H If Yes, specify Cub	lispanic Ori an, Mexicar	gin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)		ace - Amer lack, White	
	ed 🏂 Married	fy Yes 2 □ N If Yes, Give	· 194	5	1 □ Yes 2€ No	Specify:			Spec	cify:	
3 Widowed	4 ☐ Divorced	Year or Dates:	194							Whi	
(Spec	15. Decedent's E lify only highest gr	ducation ade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation <i>during m</i> os	t of work	ing	16b. Kind of	Business/I	ndustry
Elementary/Secon	ndary (0-12)	College (1-4or 5	+)			d)					
8				Truc	k Driver				Smith		snider
17. Father's Name (First, Middle, Las	t)						e (First, Middle, M	faiden Surn	ame)	
John	Ibex					Ros	sa N	usbaum			
19a. Informant's Na	ame/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	an <i>d Numbe</i>	er or Rui	ral Route Number,	City or Tow	n, State, Zi	ip Code)
Julia Ibe	ex	Wife	:	2616	Youngs La	ane	Wes	tminster	, MD	21158	3
20a. Method of Disp			20b. Plac	e of Dispo	sition (Name of matory or other pla	ce)		Date	20c. Location	n - City or T	own, State
	□Cremation 3 L 5 □ Other (Speci	Removal from State			Mem Gard	1	2/17	/2009	Finkch	nira	Maryland
21. Signature of Fu		**	المالات ا	22	2. Name and Addre	ss of Facilit	by Dacai.	tta Fina	~~] IIc	ome c	Chapel, PA
1 July	-K.A	el		1	12 Washir	arton	DY LTT	Westmin	rai no	א אווג	21157
23a Part1 Enter th	he disease or con	nplications that caused	the death								Approximate
shock, or hea	rt failure. List only	one cause on each lin	е.	A		1 5	/		,		Interval Between Onset and Death
Immediate Cause (disease or condition resulting in death)		a Oreles	nus	culo	n acci	din					1 ml
resulting in death)		Due to (or as a	conseque	nce of):				Diseas			2
Sequentially list cor	nditions.	b. artin	ascl	crot	ne Vac	ecul	ne	Nuseus	_		20 yrs
Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or	mediate rlying	Due to (or as a	conseque	nce of):							V
triat iriillated everits		c. Deale	ites								10 grs
resulting in death) L	ast	Due to (or as a	a conseque	nce of):							
		d. Hyn	estes	nin	1						20 yru
		71									
IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outcome 1 □ Live birth			Ectopic pregnanc	/			23d. [Date of deliv	/ery

Physician /Medical Examiner

1 - For State Registrar 1. Decedent's N

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
FEB 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Funeral Director

To Be Completed by

Physician /Medical

Examiner

Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence Due to (or as a consequence d. It yperforms a consequence de la performance della perform					10 yrs
nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3 Ectopic p			23d. Date of de Month	elivery Day Year
by	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying o	cause given in Part I.	23e. Did tobacco		to the cause of death? Probably 4 □Unknown
Completed					24a. Was an autopsy performed? 1∐ Yes 2☑1	prior to death?	utopsy findings available completion of cause of s 2 No
Be	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
To E	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DO	OA Other: 4 Nursing H	Home 5 Residence	6 □Other (Sp	ec <i>ify)</i>
	27. Manner of Death 1 ⚠Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e 28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factor fy)	y, office	28f. Location (Street City or Town, Sta	and Number or F ute)	Rural Route Number,
Medical (29a. Certifier 1 💢 CertifyIng Ph (Check only one) 2 ☐ Medical Exar	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and plac n, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner a and place, and du	is stated. ue to the cause(s)
Ž	29b. Signature and title of certifier		29	c. License number	29d. D	ate signed (Mor	th. Dav. Year)

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

WIL 10

Victory

3337 Victor 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Earle A. Jones February 2009 1:30 A 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Huntingtown Calvert 2097 Plum Point Road 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours 1 □XM 2 □ F 87 Yrs 216-18-5824 May 20, 1921 Maryland Usual Residence of Decedent 10a. State 10b. Counfy 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2097 Plum Point Road 20639 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1942 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No Specify: Specify: 1945 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Jones Lena Morsell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Juanita Jones - Wife 2097 Plum Point Road, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Plum Point UMC Cem. 2/13/2009 Huntingtown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Glade Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eacly line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ovens Due to (or as a consequence of): Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 C Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical **Examiner**

Physician

/Medical

Director

Funeral

3

Completed

Be ပ MD

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Examinat must be notified at

filed within 72 hours after death with Hygiene.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical þ Completed

the burial-tran and attending physician for use as the buria ģ signed t certificate has page 2 s Be Certification: To this After thi funeral

The law requires that the death certificate be executed

Box 68760,

P.O. I

Division of Vital Records,

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Part II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.
Multim	e Muelona

TE TES ZE	THO 3 PRODUCTION
24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No
(Check only one)	
ne 5 Residence 6	Other (Specify)
8d. Describe how injury	occurred

				performed death? 1 □Yes 2 No 1 □ Yes 2 No						
25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	utpatient 3 🗆 DC	g Home 5 Residence 6 □Other (Specify)							
27. Manner of Death Natural 5 Pending Accident investigatio	(<i>Month, Day, Year</i>) In	Time of 2 Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred						
3 Suicide 6 Could not b 4 Homicide determined	building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier Certifying Pl (Check only 2 Medical Example)	nysician: To the best of my knowledge miner: On the basis of examination ar	e, death occurred	at the time, date and place, in my opinion, death occ	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)						

2015	Cianat	ura and	title of c	artifiar
29U.	Signati	are arro	line of c	ermier
		/	- 1	NN
		-		VV

29c. License number 0027189 29d. Date signed (Month. Day, Year) 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NSAF

28W 5+1 State

the Hospital or Attending Physician:

after death. neral Director: /

within 24 hours a
To the Funeral I

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature

and manner stated

Registrar

Physiciar
/Medica
Examine

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time ZY Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Exprintment or other traumatic event, it is Medical Exprintment or other traumatic event, it is Medical Exprintment or other traumatic event, it is Medical Exprintment.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Sta Regist

	1 - State Registrar Amended#31perFCHD	Cer	tificate of Deat	th	Reg.	leg. No.						
ion	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death					
ian cal	WILLIAM ROBERT	JOHA	NSEN	I	FEBRUARY	Day Year 14,2009	1:04P M					
ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location	on of Death		4c. County of Deat						
	FREDERICK MEMORIAL HOSPITAL		FREDERI									
	5. Social Security Number 044-26-4747 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last	t birthday) _ Yrs.	If Under 1 Year If Und Months Days Hour	rs Min.	8. Date of Birth (Month, Day, Ye Iarch 16,	ar) Co	hplace (State or Foreign untry) nnecticut					
	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Loc	ation				10d. Inside City Limits					
Completed by Funeral Director	Maryland Frederick Frede						1 □ Yes 2 No					
ä	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	untry?					
ala	2903 Kling Court	1	21703			United						
Ë	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Hispanic Yes, specify Cuban, Mexi	: Origin? (Spec ican, Puerto R	cify Yes or No- ican, etc.)	14. Race - Ame Black, White						
b P	1 ☐ Never Married 2 Married 1 MYes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Vietnan	1	□Yes 2 🖺 No Spec	cify:		Specify:						
- Pe			ent's Usual Occupation		166	WIT . Kind of Business/	lite					
plet	(Specify only highest grade completed)	(Give k	ind of work done during n O NOT use retired)	nost of working	7	. rung or Eddinesor	, industry					
E O	Elementary/Secondary (0-12) College (1-4or 5+) 5+	Physi	cal Plant D	irector	_	Smith Co	11100					
Be C	17. Father's Name (First, Middle, Last)				First, Middle, Maid		711cgc					
2	Edwin S. Johansen		Mar	gerie N	icIlvane							
Г		19b. Mailing	Address (Street and Nur	0		ty or Town, State, 2	Zip Code)					
	Joans S. Johansen/ Wife	2903	Kling Court	. Frede	erick. Ma	ryland 2	1703					
	20a. Method of Disposition 20b. Place	e of Disposi	tion (Name of	Da		. Location - City or						
	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Stauffer Crematory Inc 2/17/2009 Frederick, Maryland											
	21. Signature of European Service Accesses 22. Name and Address of Facility Stautier Funeral Homes P. A.											
	Ladel () WM	16	21 Opossumto	own Pik	ke, Frede	rick, Maj	yland 21702					
	23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one paure on each line.						Approximate Interval Between					
	Immediate Cause (Final	N A 100	(2)4			J	Onset and Death					
	disease or condition resulting in death) a. Due to (or as a consequence of):											
	CTV											
Je.	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying b. CTVV NOS iS Due to (or as a consequence of):											
ami	that initiated events	tis										
ŭ	resulting in death) Last Due to (or as a consequence											
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an/	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy			23d. Date of delivery						
sici	1 Yes 2 No 4 Pregnant at time of death		Other (specify)			Month	Day Year					
Physician/	9 Li Onknown											
	Part II. Other significant conditions contributing to death but not resulting	g in the und	erlying cause given in Pa	ırt I.		\	the cause of death?					
ted					1 🗆 Yes	2/10 3 □ Pr	obably 4 Unknown					
뤋					24a. Was an autopsy	24b. Were au	topsy findings available					
Completed by					performed 1 □ Yes 2 ☑	? death? No 1 □ Yes	2 \Bo					
Be	25. Was case referred to medical examiner?			ace of Death (Check only one)							
	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/	Outpatient/		Nursing Home	e 5 Residence	6 ☐ Other (Spec	cify)					
ü	27. Manner of Death 28a. Date of Injury 28t 1 X Natural 5 ☐ Pending (Month, Day, Year)	b. Time of Injury	28c. Injury at Work?		d. Describe how in	jury occurred						
cat	2 Accident investigation 3 Suicide 6 Could not be		M 1 □Yes 2									
E	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Street and Number or Town, State)											
ပိ	29a. Certifier 17 Certifying Physician: To the best of my knowled											
Medical Certification: To	29a. Certifier (Check only one) Y Certifying Physician: To the best of my knowled Medical Examiner: On the basis of examination and manner stated.	age, death and/or inve	occurred at the time, date estigation, in my opinion, o	e and place, ar death occurred	d due to the caused at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)					
Me	29b. Signature and title of certifier		29c. License numbe	er	29d.	Date signed (Month	, Day, Year)					
MDD 35106 2/15/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
										Dr. Nam MD 400 West 7th Street,		•
te	31. Date filed (Month, Day, Year) 32. Registrars Signature		- LLCR, Halyl	- GIIG 21		li	backer					
ar	EED 4 ACCOUNT	1 4	FEB	17 20	39 Dene	va B.	y was					
	a con a by	and the same	A 95 cm	_	/							

	Registrar			Certificate of	Dealli		Reg. No.	009	00400
n						Month	Day	Year	3. Time of Death
1				4h City Tayya	au Lanation of Day			2009	6:15 PM
		,					1 -		1
	5. Social Security Number 6.			day) If Under 1 Yea	If Under 24 Hr	S Dete of Di	41.	9. Birth	nplace (State or Foreign
-	717 07 7770	VLM 2LIF	96 Y	s. World bay	TIOUIS IVIII	July 7	, 1912	2 Ăĩ	abama
			10c. City, Town	or Location				· T	10d. Inside City Limits
į	Maryland Carol	ine		Ri	dgely				1 ∐Yes 21X No
ě	10e. Street and Number			10f, Zip Code			10g. Citizer	n of What Cou	intry?
<u>a</u>	23635 Henry Ro							U.S.	Α.
		Armed Forces?		 Was Decedent of If Yes, specify Cu 	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No rto Rican, etc.))- 14.	Race - Amer Black, White,	
≥	3 Widowed 4 Divorced	If As Give -		1 □Yes 2 X □No	Specify:		St	pecify: B1	ack
ered	15. Decedent's E	ducation	16a. D	ecedent's Usual Occi	pation	arkina	16b. Kind	of Business/Ir	ndustry
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	•	, ,,			t and Number or F	Rural Route Numb	er, City or To	own, State, Zi	p Code) 21902
	Aimee Saylor (De	cedent Aff	airs) V.	A. Marylan			stem,	Perry	Point, MD
		☐Removal from State	20b. Place of D	isposition (Name of crematory or other plants	(00)	-	20c. Locat	tion - City or T	own, State
-	4 □ Donation 5 □ Other (Spec	ify)		etery	1027	/30/09	durloc	k, Mar	yland
	21. Signature of Funeral Service Lice	ensee 12 N	2006	Lee A. Pa	tterson 8		neral	Home,	P.A.
	23a. Part 1. Enter the disease, or cor	nplications that caused	the death. Do not	Perryv enter the mode of dy	ille, Mai	cyland ac or respiratory a	21903	-0766_	Approximate
	Immediate Cause (Final	one cause on each iii	ne.		0-1		,	,	Interval Between Onset and Death
	resulting in death)	· · ·	100		taum				Unknows
	gequentially list conditions, Coronary Artery Disease								
<u> </u>	ra any, leading to immediate cause. Enter Underlying Cause, (Disease or injury								
-γα	that initiated events	c. Due to (or as	a consequence of)	Melutu	8 11				
5		⊾d.							
	IE CEMALE.			•					
	23b. Was decedent pregnant			3 ☐ Ectopic pregnan	су		23d		•
200	1 ☐ Yes 2 ☐ No	4 □ Pregnant a 9 □ Unknown	t time of death	5 Other (specify)				Month	Day Year
		contributing to death b	ut not resulting in th	e underlying cause gi	ven in Part I.	23e. Did to	obacco use	contribute to t	he cause of death?
<u>.</u>						1 🗆 ١	/es 2 □ N	lo 3∐ Prol	bably 4 🔀 Unknown
						24a, Was	an 2	4b. Were auto	opsy findings available
5						autop perfo	rmed?	prior to co death?	impletion of cause of
					26. Place of De			1 Li Yes	2 LIN0
2	1 Yes 2 No			Ment 3 LI DOA	4 Mursing I	lome 5 ☐ Resid	dence 6	Other (Special	(y)
	1 Natural 5 ☐ Pending	(Month, Day	ry 28b. Tim <i>y, Year)</i> Inju	ry Wo		28d. Describe h	ow injury oc	curred	
	3 Suicide 6 Could not b	e 200 Blood of Inju	Irv - At home farm		Yes 2 □No	29f Location //	Time to and \$1	lunch as a la Florida	I Day to Alexander
	4 ☐ Homicide determined	building, etc	c. (Specify)	street, lactory, office		City or Tox	ireet and N n, State)	umber or Hura	al Houte Number,
	29a. Certifier 1 Certifying P	hysician: To the best	of my knowledge, d	eath occurred at the	ime, date and plac	e, and due to the	cause(s) an	d manner as s	stated.
	one)	miner: On the basis of and manner sta	t examination and/cated.				date and pla	ace, and due to	o the cause(s)
1	29b. Signature and title of certifier	$m \sim m$	^	29c. Licen	se number YA S	1	-		
	PRING	wholly	WU		72692	L. '	rebrui	ary 12	13004
3	0. Name and address of person who	completed cause of d	eath (Item 23a) (Ty	pe, Print)	stem De.	ory Doint	MO -	2,000	
- N	DEDOLUNG DOLLUCK	AN HILLOR	CALLENG TIDA	FILD CALL O	121 1 6	1 / 2 / 2 /	11100	メリフひょ	
	included of the complete of the second of the complete of the	4a. Facility Name (If not institution, g. 14 19-05-7578 Usual Residence of Decedent 10a. State 10b. County Maryland Carol 10e. Street and Number 23635 Henry Route 10e. Street 10e.	4a. Facility Name (If not institution, give street and number, NAME (If not institution, give street and number, NAME (If not institution, give street and number) 5. Social Security Number	Esau Jones 4a. Facility Name (If not institution, give street and number) VAMANUAL HEALTH (ARE SYSTEM) 5. Social Security Number 419-05-7578 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of State 10c. Street and Number 23635 Henry Road 11. 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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Kirkpatrick Jave Kvle 2009 1036 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner memorial hospital Cumberland
If Under 1 Year | If Under 24 Hrs. Allegany
9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ▼ M 2 □ F 51 Director 07/09/1957 229-92-4059 Minnesota Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumetic event, the Medical Evaminar must be notified at 1 ☐ Yes 2 XNo Director WIN Ridgeley Mineral 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a RR 1 Box 315 26753 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumetic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ 3 Widowed 4 Divorced White Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled None 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Betzler Kirkpatrick Phvllis Elaine ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RR 1 Box 315, Ridgeley, WV 26753 Cassandra R. Kirkpatrick / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State Cumberland Crematory 02/13/2009 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Deensee 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Septic Shock /Medical Due to (or as a consequence of): Examiner Bilateral Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alcoholic Cirrhosis of Liver 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hepatic Encephalopathy, 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Acute Renal Failure 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ours after death. Ieral Director: A filled in by the fu investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 712 517 Oldtown Road, Cumberland, MD Nagaratnam A. Ranjithan, M.D., 32. Registrar's Signature 31. Date filed State

DHMH 17 Rev 1/2001

Registrar

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

FEB 18 2009

32. Registrar's Signature

BRECHA

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 17, 2009 **Physician** 5:50 a M Anna M. Keller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ellicott City Howard Ellicott City Nursing&Rehabilitation 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 11/2/1924 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 21 F Days Hours Min Wisconsin 199-12-8999 84 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Ellicott City Md. Howard 10g. Citizen of What Country? 10e. Street and Number 21042 USA 2946 Brookwood Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 至 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes Ž No SpecifyWhite þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Hornacek Julia Churock ပ 19a. Informant's Name/Relationship (Type. Print)
Edward E. Keller/husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2946 Brookwood Rd. Ellicott City, Md. 21042 permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any injury or other traum once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Bunal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beaver Falls Cemetery 2/21/2009 | Beaver Falls , Pa. 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, Md. 21043 MOO845 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): **Physician** Dement monetos disease or condition resulting in death) /Medical Examiner Pheumonie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner heart diseance Amerosderonc attending physician and for use as the bunal-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation Injury To the Hospital or Attentums within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

(4) as

Division or Vital Records. P.O. Box 68760.

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year) FEB 18 2009

SHALL NIYALA



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9650

00053150

FANTIAGO ND SUITE110

FEB 17 2009

COLUMBIN

MD LIOYS

 $\mathcal{H}OSTAS$ PASUALIA G. Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please Type or Print State of Mar 1 - State Registrar	yland / Depa		lealth and M	lental Hygi	-	06487
Physici /Medio		1. Decedent's Name (First, Middle, Last) Paskalia G.	Kosta	S		2. Date of Death Month February	Dav Year	3. Time of Death 7:08A
Examir	er	4a. Facility Name (If not institution, give street and number) Prince George Hospital Cent	er	4b. City, Town, or Cheverly	Location of Death		4c. County of Dea Prince Ge	
Funeral Director		5. Social Security Number 6. Sex 7. Age (1	In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Apr. 19,	Year) 9. Bir	thplace <i>(Stat</i> e or Foreign ountry) SACHUSETTS
filed within 72 hours after death with the Maryland Hygiene. Uther than "natural", or items 23a or 28a-f show ent, the Marical Examination with the cutting a	Director	Maryland Prince George	Oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
tth with the 23a or 2	ral Dire	10e. Street and Number 10450 Lottsford Rd. Apt. 400	02	10f. Zip Code 2072.	L	109	g. Citizen of What Co USA	untry?
permit. Fages 1 and 2 should be filed within 72 hours affer death with the Maryls Important of Health and Mental Hygiens [Important if flem 27 is marked other than "natural" or items 23a or 28a-f sho any Injury or other traumatic event, I'm Marical Examination used to natify of once.	by Funeral I	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	r Married 2 Married 1 Yes 2 No			ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	
ithin 72 hd ne. han "natui Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. L		furing most of workii)	ng	6b. Kind of Business/	Industry
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should b nd Ment marked ımatic e		George Zevitas 19a. Informant's Name/Relationship (Type. Print)	apapetric	lis Dity or Town, State, 2	Zin Codo)			
Tange		Constantin J. Kostas	10450) Lottsfo	rd Rd. Ap	t. 4002 N	Mitchellvi	11e,MD.2072
nt. Pages lartment of ortant: If it Injury or o	ļ	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) 21. Signature — uneral Service Licensee	20b. Place of Dispo- cemetery, cren St. Demet	crios Cem	. 2/16	/2009 Ar	nnapolis, alas Funer	Maryland
any per	4 4	23a. Party. Enter the disease or complications that caused the	gewater,MI					
Z de la	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Separation of the condition of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cause of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	onsequence of .	yndre Trouct	one Infe	ctdon		Onset and Death
attending for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of particle 1 Live birth 2 2 4 Pregnant at time 9 Unknown Unknown 1 25c. If yes, outcome of particle 25c. If yes, outcome of particle 1 Live birth 2 25c. If yes, outcome of particle 1 Live birth 2 25c. If yes, outcome of particle 25c.	∃Fetal déath 3 ⊑	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
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this cer	: To Be	examiner? 1 Yes 2 No Hospital: Inpatient	2 ER/Outpatient	3 DOA Othe	4 LI Nursing Hon		e 6 □Other (Spec	ify)
death. tor: After the funer	cation	27. Manner of Death 1 Natural 5 Pending (Month, Day Ye 2 Accident investigation 3 Sulcide 6 Could not be	8d. Describe how i					
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the Fun	ledica	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated	amination and/or inv	estigation, in my op	inion, death occurre	nd due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To	2	29b. Signature and title of certifier Elley	ans	29c. License			Pate signed (Month	
Le De		30. Name and address of person who completed cause of death DUYA VERWA 7525 G-HE	nany Co		re Green	helt my	ehnung DZC7=	70
Stat Registra	e ir	31. Date filed (Month, Day, Year) FEB 13 2009 32. Registrar's	Signature V	arke				

		1 - For State Registrar	State of Maryland		artment of F		_	giene Reg. No 2 () ()	9 06488		
Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of De	eath	3. Time of Death		
/Medica	al	Willis J.	Kent				Feb. 8	2009	22:40 p M		
Examine	r	4a. Facility Name (If not institution, give s Prince Georges Ho	· ·		4b. City, Town, or Chever	_	Death	4c. County of			
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days		Min. 8. Date of Bir (Month, Date Nov. 8)	th (9. Birthplace (State or Foreign Country)		
Director		Usual Residence of Decedent	M 2□F 59	Yrs.	Wienins Buys	110013	Nov. 8	1949	Virginia		
yland how		10a. State 10b. County D. C.	10c. City,	Town or Lo	cation				10d. Inside City Limits		
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th with ti	ral Dir	3541 11th Street,	N. W. #B1		10f. Zip Code 20010	O		U . S .			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Medical Evarifier must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1		Vas Decedent of H fYes, specify Cuba □Yes 2⊠No	ispanic Origi n, Mexican, Specify:	in? (Specify Yes or No Puerto Rican, etc.)		American Indian, White, etc. Black		
5-0	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Occupa	ation	of working	16b. Kind of Busi	ness/Industry		
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other vent, t	e e	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, Middle,				
Maryland 21215-0036 d 2 should be filed within 72 hours att lith and Mental Hygiene. Z' Is marked other than "natural", or r traumatic event, In Mulcul Econi	0	Willis J. Kent,					hemina Ken				
and 2 sh ealth and n 27 Is n		19a. Informant's Name/Relationship (Type Diane Hall (Gu	ne. Print) n ardian)	19b. Mailin	g Address <i>(Street a</i> B Martha	and Number Street	or Rural Route Number Foresty	er, City or Town, St ville, Md			
Baltimore, permit. Pages 1 ar Department of Hea Important: If item: any injury or othe	1	20a. Method of Disposition 1 Burial 2 Coremation 3 Re	20b. Pla cer emoval from State	nce of Dispos metery, crem	sition (Name of latory or other place	02	Date /17/2009	20c. Location - Ci	ty or Town, State		
altin	1	4 □ Donation 5 □ Othe (Specify) 21 signature o Furieral Servix License	Cne	sap ea r	ce Cremat	ory 52	71772003				
© 88 5 8 8	1	Xepsy a val	100251	34Z	7 14th S	n Fune	eral Home, NW Washi	Inc. Ington, D	.C 20010		
		23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death									
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0, e executed an and rial-transit	<u> </u>	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	nce of					-			
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x 68 ertifica ding pt e as th		IF FEMALE:									
P.O. BOX 6 hat the death certifi d by the attending letached for use as Dhysician/Ma	alcia!	in the past 12 months? 1 □Yes 2 □No	ic. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of Month			
P.C		9 □ Unknown Part II. Other significant conditions cont		ing in the un	derlying cause give	n in Part I	23e Did to	shacca usa contribu	ite to the cause of death?		
I Records, P.O. The law requires that the date has been signed by the page 2 should be detached	2								☐ Probably 4 ☐ Unknown		
CD 28 28 CD CD	101			_			24a. Was a		re autopsy findings available r to completion of cause of		
							perfor	med? dea			
Of Vita Physicism: This certific al director,	ונ	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☑ Inpatient 2 ☐ Ef	Z/Outmatiant	0.0		Death (Check only or				
on of ding Phys h. After this funeral dir		27. Manner of Death 1 ☑ Natural 5 ☐ Pending		8b. Time of Injury	28c. Injury Work	4 LJ Nursi	ing Home 5 Resid	ence 6 Gother ow injury occurred	(Specify)		
LIVISION If or Attending after death, Director: After d in by the funer		2 Accident investigation 3 Suicide 6 Could not be			M 1 □ Y	es 2 □ No					
DIVISION OF ital or Attending Phys Its after death, al Director: After this led in by the funeral dir Certification: To		4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stree	et, factory, office		28f. Location (S City or Tow	treet and Number on, State)	or Rural Route Number,		
			cian: To the best of my knowledger: On the basis of examination	edge, death	occurred at the time	e, date and	place, and due to the	cause(s) and mann	er as stated.		
the Hosp ithin 24 hou the Fune ompletely fi	-	one) 29b. Signature and title of certifier	and manner stated.	and or mive							
F ≥ F 2		15 a 4 a	Brach		29c. License	140		29d. Date signed (A	топіп, Day, Year)		
02	3	30. Name and address of person who com	6 //	1 (A 1.		9 101	S ==		
State		Dr. Kauren Brooke 31. Date filed (Month, Day, Year)			Center	one	verly Mi	0 2078	65		
Registrar		FEB 1 8 2009 Sen	32. Registrar's Signatur	C.							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	01010	nai yiana i	Cer	tificate	of Dea	ith		Reg. No. 2	009	064	89
	Physicia	an .	1. Decedent's Name (First, Middle	e, Last)						2. Date of De Month	ath	Year	3. Time of De	
	/Medic		Marguerite Irene Logue					-		02	13	09	0925	М
	Examin	er	4a. Facility Name (If not institution WMHS-BRADDOCK		er)			vn, or Locat ERLANI	tion of Death		4c. County of Death ALLEGANY			
**	Funeral		5. Social Security Number	6. Sex , 7. /	Age (In yrs. last b	oirthday)	If Under 1	ear If Ur	nder 24 Hrs.	8. Date of Bir	th			oreign
	Director		212-32-8022	1□M 2 X F	73	Yrs.	Months D	ays Ho	urs Min.		rth ay, Year) 9. Birthplace (State or Foreign Country) st 01, 1935 Maryland			
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation						0d. Inside City L	Limits
	Aaryle f sho	or		egany	Ellser								1 ∑Yes 2	
	the h	Director	10. 01. 111. 1	of N. Timber Tra		эцс	10f. Zip Co	ode		-	10g. Citizen o	of What Cou	ntry?	
	h with	al Di	1430	77 N. Hilliber Ha	и коац		2152	9			U.S.A.			
	ems ser min	Funeral	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S.	13. V			c Origin? (Sp xican, Puerto	ecify Yes or No Rican, etc.)		lace - Ameri		
36	should be filed within 72 hours after death with the Maryland Ind Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show umatic event, I'm Medical Evanting must be notified a	by Fu	1 Never Married 2 Marr	ied 1 □Yes 21 If Yes, Give	No		I∐Yes 21		ecify:	, nour , orony	Spe		etc.	
21215-0036	hour	ed b	3 Widowed 4 Divorced	Year or Dates	3:	a Decer	fent's Usual C	occupation			16b. Kind of	Whi		
212	in 72 in "na Vedic	Completed	(Specify only higher			(Give life. L	kind of work of OO NOT use r	lone during etired)	most of work	ing	100.11110	540600,111	adon y	
21.	d with giene er tha	Som	Elementary/Secondary (0-12)	2	1 3+)	unit s	ecretary				hospita	1		
Maryland	be file tal Hy d oth	Be	17. Father's Name (First, Middle,	Last)				į.		e (First, Middle	, Maiden Surn	ame)		
<u>X</u>	ould I	ပ	Raymond Neder		1				Beatrice R					
<u>a</u>	d 2 sh th and 7 is n traun		19a. Informant's Name/Relations Ray Logue	hip (Type. Print) husband	19		g Address <i>(S</i> 'N. Timb é			ral Route Numb		vn, State, Zij rvland	21529-	
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Madical Examination in all be notified at or other traumatic event, I'm Madical Examination.		20a. Method of Disposition	nusbanu	20b. Place		sition (Name			rslie Date	20c. Locatio	7		-
<u>o</u> E	Pages nent of ant: If its ary or o		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		e		natory or othe Episcopal		y Februa	ary 17, 2009	Mount S	avage M	laryland	
altimore,	permit. Page: Department o Important: If any Injury or once.		21. Signature of Funeral Service		/		Name and A		-1					
m	a m Pe		John 1	Mura		1	Durst Fu	ıneral H	ome, 57	Frost Ave.	, Frostbu	rg, MD	21532	
			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately Immediate Cause (Final											
and a	Physician		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as, a consequence on):											201
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×	certific Iding p	/Me	IF FEMALE:	23c. If yes, outcon	ne of pregnancy	\$ T					024	Date of deliv		
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J.	t the c by the achec	Physician/	9 Unknown	9 ☐ Unknow	1									
S,	w requires that the de been signed by the should be detached	by P	Part II. Other significant condition	ons contributing to death	but not resulting	in the ur	nderlying caus	se given in F			tobacco use co	ontribute to t	he cause of deal	th?
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ပ္သ	e law r has be je 2 sh	Completed	Soizure diss	dor		<u></u>	eural	cttu	5 20	24a. Was	psy	prior to co	ppsy findings ava	ailable se of
	Th ate pag	Co	Seps.s;			(-	chile	na	tisber	1 □ Yes	prmed? 2.E. No	death? 1 ☐ Yes	2 🗆 No	
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<u></u>	tending Jeath. tor: Afte the fun	atio	↑ Natural 5 Pendin 2 Accident investig		Jay, Year)	Injury	М	Work? 1 ☐ Yes	2 □ No					
Division	r Atte ter dea recto recto	Certification:	3 Suicide 6 Could determ	not be ined 28e. Place of building,	njury - At home, etc. (Specify)	farm, stre	eet, factory, of	fice		28f. Location (City or To	Street and Nu	mber or Run	al Route Number	r,
2	oital o urs afi eral Di	Cer									·			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	edical	29a. Certifier (Check only one) 2 Medical	ng Physician: To the be Examiner: On the basis and manner	of examination	ge, death and/or in	n occurred at vestigation, in	the time, da my opinion	ite and place , death occui	, and due to the red at the time,	cause(s) and date and plac	manner as se, and due to	stated. the cause(s)	
	Го th e within Го the сотры	Me	29b. Signature and title of certific		otatod.		29c. L	icense num	ber		29d. Date sig	ned (Month,	Day, Year)	
b) B Coo	→			D	006	0420	7	2/19	1/0	9	
	7		30. Name and address of person	who completed cause o	f death (Item 23a	ı) (Type,	Dut at			0				
سن	nds		DR. Blanche	MAYROM	atis	900	Seti	IN DR	IVE,	Cumbe	Rlanc	1, MC	21500	2
	Sta Registr		31. Date file (Bab) Pay Y20	19 Cenery	strar's Signature	ark								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 1 - For State Registrar 06490 Certificate of Death Reg. N 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 1 2009 2:43 rebruary /Medical Ella Genevieve LEWIS 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Examiner Washington

9. Birthplace (State or Foreign Country) Washington County Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 ☐ M 2 🔀 F Yrs. 90 **Director** May 29 1918 214-09-8059 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ▼ No Director Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9700 Sharpsburg Pike Funeral 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 21 No δ Specify: 3 ♥ Widowed 4 Divorced White natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Sealer Aircraft Mfg permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked other any liquy or other traumatic event, ODG. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Howard L. Sprecher L. Catherine McCaulev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9700 Sharpsburg Pike, Hagerstown, Md. 21740 of Disposition (Name of Disposition (Name of Disposition) Robert Lewis - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 2/20/09 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility Signat of Funeral Service Licensee Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** to crand disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician al Box 68760, Physician/Medical attending pt IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ş 1 Yes 2 Ho 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 DN 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be examiner? Hospital: 1 Anpatient Other: 4 \sum Nursing Home 1 ☐ Yes 2 UNO 2 ER/Outpatient 3 DOA uneral dir 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of ath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending s after death.

I Director: Aid in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital within 24 hours a

To the Funeral I

completely filled 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

JUDITH

31. Date filed (Month, Day, Year)

3H-6

251

and address of person who completed cause of death (Item 23a) (Type, Print)

MBAOUA, M

162586

Antietam St. Haperbu

2003

State of Maryland / Department of Health and Mental Hygier For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** February 10, 9:45 pM Elizabeth 2009 Link /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Althea Woodland Nursing Home Silver Spring
If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month Day, Year) April 19, 1928 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 ☐ M 2 🛣 F Nebraska 578-40-7591 Director 80 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Important: If item 27 ie marked other then "naturel", or iteme 23a or 28a-t ehow any injury or other treumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ₩ No Director Maryland Montgomery Brookeville 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 18804 Alpenglow Lane 20833 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Harry Guest Bertha Minnie Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan E. Link/Son 20b. Place of Disposition (Name of cometery, crematory or other place)

18804 Alpenglow Lane, Brookeville, Date Place Communication (Name of Feb. 14. MD 20833 20a. Method of Disposition 20c. Location - City or Town, State Feb. 14, 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 2009 Rockville, Maryland 22. Name and Address of Eachity Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service License 500 University Blvd., W, Silver Spring, MD 20901

Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ZHE IMER'S **Physician** egRS /Medical Due to (or as a consequence of) Examiner Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed es the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? detached for Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed certificete 1 Tes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this the funeral 28c. Injury at Work? 27. Mannes of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 Yes 2 No hours after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) re Lu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4203 Queensburg Rd Huattolle MD 20781 DEL 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2009 061.92

			1 - For State Registrar	State of Ma	ryianu / L	Certific	ate of	Death	иепіаі пу <u>і</u> і	gierie, Reg. No. ⁽	2009	06492	
V	Physici	an	1. Decedent's Name (First, Middle, I						2. Date of Dea	ath		3. Time of Death	
	/Medic	al	Harold George 4a. Facility Name (If not institution, g			4h C	ity Town o	r Location of Death			6, 2009		
1	Examin	er	12847 Homestead	,			sby	Location of Death			alvert		
73	Funeral Director		5. Social Security Number 6. 578–28–1695 Usual Residence of Decedent	1MM 2□ F	(In yrs. last biri	thday) If Ur Mont	hs Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day August 1	y, Year)	Co	hplace (State or Foreign untry) sachusetts	
	yland low at		10a. State 10b. County		10c. City, Towr	or Location						10d. Inside City Limits	
	e Mar ka-f sh tiffed	ctor	Maryland Calvert		Lusby						1 □Yes 2MNo		
	vith th	Dire	10e. Street and Number			10f.	Zip Code			10g. Citizen of What Country? United States			
	ns 23	Funeral Director	12847 Homestead I	12. Was Decedent E	ver in U.S.	13. Was De	20657	lispanic Origin? (Sr	pecify Yes or No-		4. Race - Amer		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		1 Never Married 2 Married 3 Widowed 4 Divorced	Apped Forces?	0		specify Cubi	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	1	Black, White Specify: Whi	e, etc.	
2	72 hc "natu	etec	15. Decedent's (Specify only highest of	Education grade completed)	16a.	Decedent's U	Jsual Occup work done	oation during most of world)	king	16b. Kind of Business/Industry			
121	within ene. than '	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+		Printe:		d)		Press Operator			
2	il Hygi other rent, t	Be Co	17. Father's Name (First, Middle, La	st)				18. Mother's Nam	e (First, Middle,			4201	
<u>Jar</u>		To B	Charles Lin	ehan				Ruth Si	monds				
lar)	2 g a s		19a. Informant's Name/Relationship	, , ,				and Number or Ru			Town, State, Z	ip Code)	
ore,	is 1 and of Health item 27 other to		Tom Linehan / So	n				, Lusby,	MD 2065		-ti Oiti	- O	
	permit. Pages: Department of I Important: If ite any Injury or of		1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	cify)	20b. Place of cemeter Ft. Line	coln Cer	neterv	02/20	/2009	Brent	ation - City or wood, Ma		
g R	permi Depar Impor any Ir		21. Signature of Funeral Service Lic	ensee				ss of Facility Rau		al Hom	e, P.A.		
			23a. Part1. Enter the disease, or co	mplications that caused to	he death. Do n			00, Lusby, 1		rest,		Approximate Interval Between	
2	Physician		shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on each line	9.	nal.	_		, ,			Interval Between Onset and Death	
	/Medical		resulting in death)	Due to (or as a	consequence		10011		-			Five years	
	Examiner	Examiner	Sequentially list conditions,	b. High		press	sure					five years	
	ted nsit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence o	or):							
J.	execuin and ial-tra	Ехаг	that initiated events resulting in death) Last	CDue to (or as a	consequence o	of):						-	
68/60,	tificate be executed ig physician and as the bunal-transit	edical		d					•				
	£ 500		IF FEMALE:										
.C. Box	requires that the death cert been signed by the attendin, hould be detached for use a	ysician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome p 1 □Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death	3 □Ectopi 5 □ Other	c pregnancy (specify)	1		23	3d. Date of deli Month	very Day Year	
2	w requires that the di been signed by the should be detached	by Phys	Part II. Other significant conditions	contributing to death but	not resulting in	the underlyin	ig cause giv	en in Part I.	23e. Did to	bacco us	e contribute to	the cause of death?	
ğ	equire en sig ould b								1 🗆 Y	es 2	No 3□Pro	obably 4 □Unknown	
I Records,	The law ate has b	Completed							24a. Was a autop perfor		24b. Were aur prior to c death? 1 ☐ Yes	topsy findings available ompletion of cause of	
VITal	Physician: this certific ral director,	Be (25. Was case referred to medical examiner?	Lie onital:			011	26. Place of Deat	h (Check only or	ne)			
0	this ald	-T	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatien 28a. Date of Injury		patient 3	DOA Oth	4 Li Nursing Ho	ome 5 Resid			ify)	
	ding After fune	tion	1 Natural 5 Pending 2 Accident investigati	(Month, Day		njury M	28c. Injur Wor	yat k? Yes 2 □ No	28d. Describe h	iow injury	occurred		
DIVISION	al or Attend s after death. Il Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At home, far (Specify)	rm, street, fac	tory, office		28f. Location (S City or Tow	Street and n, State)	Number or Ru	ral Route Number,	
	he Hospital or Al n 24 hours after o he Funeral Direc pletely filled in by	Medical (29a. Certifier 1 CertifyIng I (Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner state	examination and	, death occur d/or investiga	red at the tir tion, in my o	ne, date and place, pinion, death occur	and due to the d rred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)	
	To the within 2 To the complete	Ź	29b. Signature and title of certifier				29c. Licens				signed (Month		
			(hances h	1. Bennett	MO.		1)2	5156		Febr	uary 17	7, 2009	
h	0741		30. Name and address of person when Charles W. Benne	ett, MD 1184	5 H. G.	Type, Print) Truen	nan Ro	ad, Lusby	y, Maryl	and	20657		
76	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra		A. S.	and						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06493 State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16 Julia Larkin 2009 11:25 PM 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death 355 Ocean Parkway Ocean Pines Worcester 8. Date of Birth (Month, Day, Year 9/25/1930 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Months Days Hours 1 M 2 X F 78 101-24-9388 NY Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h County 1 ∏Yes 2 X No Ocean Pines MD Worcester 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 355 Ocean Parkway 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ **X**No Specify If Yes, Give Year or Dates: Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Andrew Lamparelli Catherine Depolito 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jim Larkin / son 355 Ocean Parkway, Ocean Pines, MD 21811 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 2/20/2009 Rye Brook, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence o Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 res 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 🗆 K 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural

Physician /Medical Examiner

Department of Health al Important: If item 27 Is any injury or other trau

Pages 1

be executed

law requires that the death certificate

Box 68760,

P.0.

Division of Vital Records,

Hospital or Attending Physician: The

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ō Items 23a

Director

Funeral

à

Completed

traumatic event, the Medical Examiner must be notified at

"natural", or

within 72 hours after

d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r

Saltimore, Maryland 21215-0036

Examiner Physician/Medical þ Completed

2 Accident

3 Suicide

4 Homicide

the attending physician and hed for use as the burial-tran detached cate has been signed by page 2 should be detact certificate funeral director, Be Certification: To After this death. within 24 hours after death To the Funeral Director: the

BA4

filled in by

completely

Medical

State Registrar

28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title

Name and

29d. Date signed (Mopth, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

18

FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Day **Physician** 10:20 A M Lawson February 12. 2009 Janet Caro1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Garrett Kitzmiller 273 W. Main Street If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 220-72-4590 Maryland Director May 6, 1959 49 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Executation of the configuration Director 17 Yes 2 □ No Kitzmiller MD Garrett 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21538 United States 273 W. Main Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □Yes 2X No Specify: δ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygin Important: If Item 27 is marked other any Injury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Cysyk 2 Harry Lawson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1944 Holborn Road, Baltimore, MD 21222 Ruth Lawson, Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 2/14/2009 Cumberland, MD 22. Name and Address of Facility
David A. Burdock Funeral Home, P.A. 21. Signature of Funeral Service Licensee Katherine Durety/ N. Second St., Kitzmiller, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) the ; Ö 9 Unknown signed by t ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records. Ş 1 Yes 2 No 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy Chroniz certificate SInne 1 ☐ Yes 2 ☐ No 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4 00 64

Registrar

State

Richard A.

31. Date filed (Month, Day, Year)

FEB 17

parke

311 N. 4th Street, Oakland, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Porter,

State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12 2009 **FEBRUARY** 8:34 P GLORIA LOWE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, JUNE 5 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F Months Days Hours Min 70 Director 579-54-9413 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Expriner must be notified at once. PRINCE GEORGE'S FORT WASHINGTON MD YYes 2 ☐ No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 6801 BOCK ROAD 20744 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK If Yes, Give Year or Dates 1 ∐Yes 2X No 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2 YRS Elementary/Secondary (0-12) GOVERNMENT EXECUTIVE SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ADA BRIM CARL LOWE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4501 BIRCHTREE LANE TEMPLE HILLS, MARYLAND KRISTIN MITCHELL/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 2/19-09 Suitland, Maryland Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Seplicemia 44Knowy /Medicai Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 2 No Day Year 5 Other (specify) P.0. sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼No 24a. Was an autopsy perform certificate 1 Tyes or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 **V**No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ours after death.

eral Director: After this of filled in by the funeral director. 1 ☐ Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2.13.09 20702 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ancsikil 3-JZSilversp ROINTAN FARAHIFAR 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

FER 1 8 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Cel Opez 2032 (0 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deatl 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** Baltimore If Under 1 Year If Under 24 Hrs.
Hours Min. 5. Social Security Number Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Director 584-54-7274 10 - 13 - 52Puerto Rico Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at Yes 2 No Director 225 W. 4th St. Wilmington, DE. Delaware New Castle 19805 10e. Street and Number 10g. Citizen of What Country? Funeral 225 West Fourth Street 19805 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify þ Specify 3 X Widowed 4 □ Divorced Year or Dates: "natural", Puerto Rican 16b. Kind of Business/Industry Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than " Elementary/Secondary (0-12) College (1-4 or 5+) homemaker in the home 2 yrs. education Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Francisco Lopez Rivera Paula Reyes Laras is marked မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 other <u>Jose Lopez</u> 1401 Maryland Ave, Wilmington, DE. 19805 item (20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silverbrook Crematory 2-11-09 Wilm., DE. 22. Name and Address of Facility Wilmington, DE. 19805 تعاه Corleto-Latina Funeral Home - 808 N. Union St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) almorary /Medical Due to (or as a conse uence of) **Examiner** Dise Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last wer Examine Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) physician an as the burial-t Box 68760 Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) 2 X No detached P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? page 2 🗌 No 1 🗌 Yes 2 No 1 TYes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home Hospital: 1 ☐ Yes 2 ☑ No 1 [Inpatient 2 ER/Outpatient 3 DOA မ 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 1X Natural 5 Pending investigation (Month, Day Year) Injury 1 🗌 Yes 2 🗌 No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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n 24 hours after death.

he Funeral Director, After Hospital To the Hosp within 24 hou To the Funer completely fi

29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

94 31. Date filed (Month, Day, Year)

2009 FEB 17

32. Registrar's Signature backs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** 8:50 P FEBRUARY 17, 2009 BETTY ELLEN METZ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON RAVENWOOD LUTHERAN VILLAGE HAGERSTOWN 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🖾 F 88 220-10-8537 Director Aug. 30, 1920 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It will offer Examiner must be realthed at 1X Yes 2 No Director Washington Hagerstown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 USA 63 E. Antietam Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) waitress restaurant 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Reckley William G. Linn ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 63 E. Antietam St., Hagerstown, Maryland 21740 Wilbur L. Metz - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park 2/21/09 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ing mans Month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Heart Failure Due to (or as a consequence of): Sequentially list conditions, if any leading to annual cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has all director, page 2: autopsy performed? 1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 25 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To nours after death.

neral Director: After this
filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1⊓ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 🖳 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2-19-09 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) Street Heigestern vas DH-5 368 null

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State Registrar egistrar's Signatur

			1 _ State	ate of Marylar		artment of rtificate o		•		9 06498
			Registrar 1. Decedent's Name (First, Middle, Last)		00.	imouto o	, Douill	2. Date of De	ath	3. Time of Death
	Physici:		Bessie Lee Malott					Hebrua:	u 17 ago	ar Silson
	/Medio		4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town	or Location of Dea		4c. County of D	
			Fahrney Keedy Nursi	ng Home		В	oonsboro		Washi	ington
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Yea Months Day		n. (Month, Da	th y, Year) 9.1	Birthplace (State or Foreign Country)
	Director		214-28-5713	77	Yrs.			Aug.31	, 1931	Maryland
	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mary Frsh	jo	Maryland Washingt	on	Ha	gerstow	n			1 ☐ Yes 2 No
	h the	Director	10e. Street and Number	011	110	10f. Zip Code			10g. Citizen of What	Country?
	th wit	la la	1643 Langley Drive				21740		Ĺ	ISA
	tems	Funeral	A	las Decedent Ever in Urmed Forces?	l.S. 13. V	Was Decedent of Yes, specify Co	f Hispanic Origin? Jban, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examinar must be notified at	by F	¥ If	∐Yes 2 X No Yes, Give ear or Dates:	1	1⊡Yes 2¥∏N	o Specify:		Specify:	White
9	tural	ed	15. Decedent's Education	1	16a, Deced	dent's Usual Occ	upation		16b. Kind of Busine	White ss/Industry
215	in 72 in "na Medic	Completed	(Specify only highest grade con	npleted) sollege (1-4or 5+)	(Give life. L	kind of work dor OO NOT use reti	e during most of w red)	orking		
212	d with giene	ĕ	9	ollege (1-40/ 5+)		Homemal	ker		Н	lome
P	e file tal Hy d othe	Be (17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maiden Surname)	
yla	Ment Ment	²		vers			Virgi	nia Mae	Swain	
Mar	2 sh h and ris m		19a. Informant's Name/Relationship (Type. P		1				er, City or Town, State	-,,
e,	1 and Health em 27 ther t	1	William A. Malott, and 20a. Method of Disposition		24210	Peach sition (Name of	ree Rd.	Clarksbui Date	g, Maryla 20c. Location - City	nd 20871
Baltimore, Maryland 21215-0036	ages nt of l t: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov	al from State	cemetery, cřen	natory or other p	- :		•	
垂	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantmer must be notified at once.		4 □ Donation 5 ☑ Other (Specify) Er	топомент bre			irk ¦⊦eb fenetreiiv H	.20,2009	Williamsp	ort, Maryland
Ba	Departing Department Important Irraportant		1 me Ou						illiamspor	+, MD 21795
			23a. Part 1. Enter the disease, or complication	ns that caused the dear						Approximate Interval Between
	Physician		shock, or heart failure. List only one callimmediate Cause (Final disease or condition	De anne.	Line					Onset and Death
	/Medical		resulting in death)	Due to (or as a consec	uence of):	2		1 1		3 9
	Examiner	L	Sequentially list conditions. b.	Cerel	VOVOS(colar	Acck	Cent		94
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	uence of).					
	al-trar	xan	that initiated events c resulting in death) Last	Due to (or as a consec	quence of):					
8760,	ficate be executed physician and s the burial-transit	alE		,	,					
9		edical	u							
Box	leath certifi attending for use as	M/u		yes, outcome of pregn		1 makania manana			23d. Date of	delivery
_•	Attending Physician: The law requires that the death certire death. r death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No	☐ Live birth 2☐ Feta☐ Pregnant at time of☐ Unknown] Ectopic pregna] Other <i>(sp</i> ec <i>ify)</i>			Month	Day Year
中品	at the by the	hys	9 Unknown					1.		
Bessie L Maloth Division of Vital Records, P.	v requires that the d been signed by the should be detached	ρ	Part II. Other significant conditions contributed	ting to death but not res	sulting in the un	nderlying cause (jiven in Part I.			to the cause of death?
S so	requii	Completed						. 141	res 2∐No 3∐	Probably 4 D Inknown
Sec 3	s law has b e 2 sł	agu.						24a. Was autop	sy prior	autopsy findings available to completion of cause of
a F	ilcian: The law certificate has ector, page 2 s							perfor 1 □ Yes	rmed? death 2 ☑ No 1 ☐ Y	i? ′es 2 □ No
∠, Ş	sician: certific rector,	Be	25. Was case referred to medical examiner?	al:			ther:	eath (Check only o		
2 6	Phys er this eral dir	۲. T	I les 252NO	a. Date of Injury	ER/Outpatien 28b. Time of	T 3 DOA	4 Drivursing		lence 6 Other (S	pecify)
\(\frac{1}{2} \)	nding F th. : After e funera	tio	1 Pending 2 Accident 5 Pending investigation	(Month, Day, Year)	Injury	28c. In W M 1	ork? □Yes 2□No		,,	
Nisi V	l or Attend after death Director:	ifica	2 □ Cuiside 6 □ Could not be	e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	et, factory, office)	28f. Location (S	Street and Number or	Rural Route Number,
Bessive Division of I	s after at Dir	Certification: To	4 Homicide	building, etc. (Speci	19)			City or Tou	m, State)	
`	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier (Check only (Check only 2 Medical Examiner:	On the basis of examina	owledge, death	occurred at the vestigation, in m	time, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner date and place, and c	r as stated. due to the cause(s)
	the the the the the the the the the the	Medical	one) a 29b. Signature and title of certifier	and manner stated.		29c Lice	nse number		29d. Date sign <i>ed (M</i> o	anth Day Voor
	¥ ≥ ¥ 5	_	and the of continer			1	12-2-			
			30. Name and address of person who comple	ted cause of death (Ita	m 23a\ /Tune 5	Print)	7752	3	02-17-	2004
			Khalid Waseem, M.D.	1126 Opal			vn. Marvi	and 217	10	
	Sta	te	31. Date filed (Month, Day Year) FEB 1 9 200	32. Registrar's Signa		1 4	, Huly I	211021/		
	Registr	ar	LED TO SOM	7 Karing	A. 1	A COLUMN TO SERVICE OF THE PARTY OF THE PART				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amended#31perFCHD Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month OLA MAY MYERS February 13, 2009 P^{M} 1:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College View Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. | Months | Davs | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Day, Year)
May 10, 1926 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Country)
Virginia **Funeral** 1□M 2√2F 218-30-3161 82 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland | Frederick 1 ☐ Yes 2 ☐ No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 Toll House Avenue 21701 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify ģ 3 Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien. Important: If Item 27 is marked other than any injury or other traumatic events. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph M. Thompson Emma Jane Hoback 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connielee E. Myers / Daughter 1153-B Orchard Terrace B204, Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gardens 2/17/09 Frederick, Maryland 21. Signature of Fuheral Service License 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. Wheat 1201 NORTH MARKET STREET FREDERICK MD 21701 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on encl the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician 80 KK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 Other (specify) 1 ☐ Yes ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes P□NO 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) 1 ☐ Yes Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4☐ Hursing Home 5☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation (Month, Day Year) 1 Untural 1 ☐ Yes hours after death, uneral Director: / Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a To the Hospital 14 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

within 24

Registrar

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ORIGINAL

hamore

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shah

Hernen

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

29c. License number

60417

06500 State of Maryland / Department of Health and Mental Hygiene [] [] 9 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 18, 2009
4c. County of Death 6:50 A Mary E. McCraw /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Haure de Grace Harford Memorial Hospital Harford 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 200 F Months Days Hours Yrs. Director 214-28-4636 10/23/1920 North Carolina 88 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 □ No Director MD Havre de Grace Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 319 Revolution Street 21078 U.S.A Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4or 5+) 10 Nutrition Dietician 7 le marked other treumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: if Item 27 is marked oth any liquy or other treumatic event 9DGs. Be Estle Hurley Betty Shumake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 Revolution Street, Havre de Grace, MD 21078 Evelyn Powers Murray (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Angel Hill Cemetery 102/21/2009 Havre de Grace. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington St., Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician musti-organ failure /Medical Due to (or as a consequence of)! Examiner Severe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Staph bacterernia attending physicien and for use as the burial-transit death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) O 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ of Vital Records, 3 ☐ Probably 4 ☐ Hinknown 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: The law require within 24 hours after deeth.

To the Funeral Director: After this certificete has been sit completely filled in by the funeral director, page 2 should in the funeral director, page 2 should in the funeral director, page 2 should in the funeral director, page 2 should in the funeral director, page 2 should in the funeral director, page 2 should in the funeral director, page 2 should in the funeral director, page 2 should in the funeral director. Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ 1√10 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Datural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a, Certifier 1 🖟 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 63420 Come February 18,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Trace +avre de Do. Union Kharal 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 2 0 2009

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Registrar

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